

REPORT

East Asia and Pacific Regional Partnership Forum on CHILDREN AND HIV & AIDS

31 March – 2 April 2008
Bangkok, Thailand



Scaling Up the Response for Children

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The report on the Regional Partnership Forum on Children and HIV and AIDS captures the discussions and deliberations of the 133 delegates representing 17 countries. It affirms the commitment made at the Hanoi Consultation in March 2006 to minimize the impact of HIV and AIDS on children and young people as well as to prevent the continuing spread of HIV and AIDS by protecting children and young people from a host of vulnerability and risk factors that drive the spread of HIV in the East Asia and Pacific region. Priorities for future action and specific measures to overcome challenges in scaling up the “4Ps” based on local epidemics and to ensure better linkage between all components are included in this report.

UNICEF EAPRO acknowledges the valuable contribution of the Regional Partnership Forum management team – Wing-Sie Cheng, Regional Adviser HIV and AIDS; Yoshimi Nishino, Regional HIV and AIDS Specialist; Shirley Mark Prabhu, Consultant; and Wassana Kulpisitticharoen, Project Assistant.

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Preface

Children have been called the missing face of HIV and AIDS. While countries and regions have marshaled resources to respond to the HIV epidemic, children and young people infected and affected by HIV and AIDS have received little, if any, attention. In March 2006, participants in the three day East Asia and Pacific Regional Consultation on Children and HIV & AIDS, held in Hanoi, Viet Nam, issued the 'Hanoi Call to Action'. It appealed to national and regional leaders to put children firmly on the agenda in their HIV response. Two years later, many of those who attended the Hanoi consultation gathered in Bangkok to take stock of what progress had been made and what gaps still existed in efforts to protect, treat and care for children infected and affected by HIV and AIDS in the East Asia and Pacific region.

Convened by the UNICEF East Asia and Pacific Regional Office, the Regional Partnership Forum on Children and HIV and AIDS (or "Forum") brought together 133 representatives from 17 countries and organizations. The forum was held from 31 March to 2 April 2008 at the Imperial Queen's Park Hotel in Bangkok, Thailand.

The cause of placing children and young people on the HIV and AIDS agenda is a serious one. Young people account for about 50 per cent of all new HIV infections in the Asia-Pacific region. The numbers of infected and affected children, including orphans and vulnerable children, have been steadily rising in most countries. Most at risk are the children from groups marginalized by society, such as sex workers, drug users and migrants. As the epidemic progresses, more women and mothers are among the ranks of those living with HIV and AIDS. In the absence of comprehensive coverage, the vast majority of HIV-positive pregnant women are at risk of passing their infection on to their newborns.

Clearly, there has been progress since Hanoi. The Association of Southeast Asian Nations (ASEAN) has formally recognized the Hanoi Call to Action. Countries such as China are making the first moves toward scaling up programmes to protect, treat and care for children infected and affected by HIV and AIDS. Cambodia has reduced the percentage of pregnant women infected by HIV. More antiretroviral drugs are becoming available for children. The percentage of pregnant HIV-positive women attending antenatal clinics has declined in 11 of 15 countries in the region. Funds devoted to responding to the epidemic have been rising around the region. Country-level analyses of the situation of children are more available, legislation has been refined and policies developed. All countries have initiated a range of prevention, treatment and care options for children and young people, some are scaling up, and many countries are pursuing a family-centred response. Regional and faith-based organizations are also increasing their roles.

Nonetheless, the gaps that remain are huge. Near the conclusion of the Forum, members adopted a Statement of Commitment which called on countries to improve coverage of prevention programmes and make them more accessible to young people; continue to scale up the prevention of mother-to-child transmission (PMTCT); continue to scale up paediatric treatment; protect and support young people infected and affected by HIV; strengthen data systems along with research, monitoring and evaluation, to address stigma and discrimination; strengthen partnerships; allocate resources; encourage participation by young people and promote effective mechanisms to address violations of the rights of children and their families who are affected by HIV and AIDS.

This report highlights the substantial inputs and discourses made during the three-day Forum. It outlines several action points that aim to minimize the impact of HIV and AIDS on children and young people and to prevent the continuing spread of HIV by protecting children and young people from a host of vulnerability and risk factors that drive the spread of HIV in the region.

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Acronyms

AIDS	Acquired immunodeficiency Syndrome
ART	Antiretroviral treatment
ARV	Antiretroviral
ASEAN	Association of South East Asian Nations
AusAID	Australian Agency for International Development
BLI	Buddhist Leadership Initiative
BSS	Behavioural sentinel surveillance
CBOs	Community-based organisations
CDC	Center for Disease Control
CDHS	Cambodia Demographic and Health Survey
CHAI	Clinton Foundation HIV & AIDS Initiative
CHBC	Community home-based care
CoC	Continuum of care
DBS	Dried-blood spot
DfID	Department for International Development (UK)
DHS	Demographic Health Survey
EAP	East Asia and Pacific
EVA	Especially vulnerable adolescent
FBO	Faith-based organisation
FHI	Family Health International
FP	Family planning
FSW	Female sex worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GO	Government organization
HIV	Human immunodeficiency virus
IDU	Injecting drug user
LTFU	Long-term follow up
M & E	Monitoring and evaluation
MARA	Most-at-risk adolescent
MARPs	Most-at-risk populations
MCH	Maternal and child health
MICS	Multiple Indicator Cluster Surveys
MoH	Ministry of Health
MoSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MSM	Men who have sex with men
MTCT	Mother-to-child HIV transmission
NAP	National AIDS Programme
NCHADS	National Center for HIV & AIDS, Dermatology and Sexually Transmitted Diseases
NMCHC	National mother and child health centre
NGO	Non-government organisation
NPA	National Plan of Action
OFW	Overseas Filipino workers
OIs	Opportunistic infections
OPCs	Out-patient clinics
OVC	Orphans and vulnerable children
PCR	Polymerase chain reaction
PEPFAR	Presidential Emergency Plan for AIDS Relief
PITC	Provider-initiated testing and counseling

PLHIV	People living with HIV
PLWHA	People living with HIV & AIDS
PMTCT	Prevention of mother-to-child HIV transmission
RH	Reproductive health
RST	Regional Support Team
S & D	Stigma and discrimination
SEARO	Southeast Asia Regional Office
SRH	Sexual and reproductive health
STI	Sexually transmitted infections
T & C	Testing and counselling
UNAIDS	Joint United Nations Programme on HIV & AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	UN General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAAC	Viet Nam Administration of AIDS Control
VCT	Voluntary counselling and testing
VCCT	Voluntary confidential counseling and testing
WCRP	World Conference on Religion and Peace
WHO	World Health Organization
WPRO	Western Pacific Regional Office

Executive Summary

Background

The East Asia and Pacific Regional Partnership Forum on Children and HIV & AIDS was convened from 31 March to 2 April 2008 in Bangkok, Thailand, with 133 delegates and partners from 17 countries, representing international, regional and national organizations. The Forum was a follow-up to the East Asia and Pacific Regional Consultation on Children and HIV & AIDS held from 22 to 24 March 2006 in Hanoi, Viet Nam.

Forum objectives

The Regional Partnership Forum broadly aimed to review the progress within the East Asia and Pacific region since the 2006 Hanoi Consultation in addressing the needs of children vulnerable to, living with and affected by HIV and AIDS, and to discuss corresponding future actions. More specifically, the objectives of the Forum were to:

1. Identify achievements and progress since the Hanoi Consultation,
2. Share effective initiatives to meet the needs of children who are vulnerable to, living with and affected by HIV & AIDS, and
3. Strengthen partnerships and action to address the key issues identified within the Call to Action.

Agenda, process and output

The agenda was structured mainly around the “4 Ps” (Prevention of mother-to-child HIV transmission, Paediatric treatment, Prevention of infection among adolescents and young people, and Protection and support of children affected by HIV & AIDS). The Forum also focused on overall national achievements, especially those concerning evidence-based approaches.

Sessions were divided into seven main parts:

1. National responses following Hanoi;
2. Protection and care: Global and regional approaches;
3. Country examples responding to children affected by HIV and AIDS;
4. Evidence-based approach – progress made since Hanoi;
5. Preventing infection among young people;
6. Preventing mother-to-child HIV transmission and supporting paediatric treatment; and
7. Partnership.

During the Forum, delegates were divided into eight small groups for two working sessions. One session focused on how to link the 4 Ps around local epidemics and the other session on the next steps and priorities for future action.

A major output of the Forum was a “Statement of Commitment” that outlines the range of responses to HIV & AIDS, present challenges and future courses of action necessary to achieve the Global Campaign for the 4 Ps.

Following are the highlights of the sessions.

1. National responses following Hanoi

Representatives from six countries (Cambodia, China, Lao PDR, Philippines, Thailand and Viet Nam) reported on specific responses to HIV and AIDS following the Hanoi Consultation. A summary of the country responses is provided as follows:

- Expansion of services and increase in service uptake
- Development/review/revision/issuance of policies, frameworks and guidelines on the 4 Ps, including PMTCT, paediatric treatment and alternative child care
- Behaviour change communication through life-skills education, advocacy and awareness raising of HIV & AIDS
- Linking of HIV & AIDS into existing plans/programmes/structures
- Establishment of mechanisms for national coordination and resource mobilization, including multi-sector participation in national plan formulation
- Situation and needs assessments of children affected by HIV & AIDS, orphans and vulnerable children (Cambodia, China, Lao PDR and Viet Nam); preparation of research agenda (Cambodia)
- Development of country-specific action plans and evidence-based National Plan of Action on Children and HIV & AIDS (Cambodia, China, Lao PDR, Philippines and Viet Nam); costing of national plan (Cambodia and Philippines)
- Improvement in monitoring and evaluation of systems/mechanisms and antenatal care surveillance to inform policy and programming for children affected by HIV & AIDS (Cambodia, Lao PDR, Philippines and Viet Nam)
- Creation of national structures to facilitate implementation of 4 Ps (i.e. multi-sectoral task force on OVC in Cambodia, on PMTCT in Lao PDR and a women's group in the Philippines)
- Development of institutional capacity in paediatric AIDS care (Lao PDR) and community-based care (Philippines)
- Stigma reduction through the Buddhist Leadership Initiative (Lao PDR)
- Strong leadership support as evidenced by the continuing increase in budgetary support to HIV & AIDS (China)

Some issues and challenges faced by countries include non-segregation of HIV & AIDS data by target and age group; finding a balance between vertical and horizontal approaches; shifting focus from policy development to policy implementation; ensuring sustainability of responses; reducing resource dependency; lack of resource and technical capacities; and stigma and discrimination.

Included in these countries' future plans are the preparation of detailed and costed implementation plans; expansion of PMTCT, prevention, protection and care services; prioritization of most-at-risk populations (MARPs); decentralization of HIV programme implementation; strategic communication; strengthening the capacity of local response teams; service providers and NGOs; establishment of a national monitoring system; and the strengthening of multi-sectoral partnership and cooperation.

2. Protection and care: Global and regional approaches

This session provided technical inputs on global and regional strategies and approaches on protection and care of children affected by AIDS and orphans and vulnerable children. Key points of the presentations are as follows:

- Targeting should avoid using AIDS as a criterion for service eligibility. It should cover, in addition to the broad base of the population, the subsets of vulnerability, e.g. the poorest, most excluded and marginalized and those that lack access to basic services, as well as adolescents and youth. Targeting could be geographic and poverty-focused. It is crucial to be clear about which children need to be targeted for what policies and services.
- Institutional care should be the last resort. Priority should be given to home-based and community-based care.
- Studies have shown that HIV-affected children are more vulnerable to psychosocial problems than non-affected children. However, a study made in Thailand shows that neither caregivers nor health workers identified psychosocial needs of HIV-affected children as important. Stigma and discrimination against persons living with HIV remain prevalent.

- Legal frameworks for protection and care of children affected by HIV & AIDS are weak in most countries. Also, protection and services for street children are poorly developed.
- Social welfare programmes, such as cash transfers to poor families, may be helpful, but information on specific impacts upon HIV-affected children in the region is limited. A 'transformative social protection' framework should go beyond welfare payments to the poor.
- Continuum of care (CoC) provides a comprehensive service package for adults, children, youth and families vulnerable to, living with and affected by HIV. There is a need to link the CoC approach with the National Plan of Action for Children & HIV, to target most-at-risk populations, to develop new CoC programmes based on local need and on the specific needs of children and youth living with HIV, and to build the capacity of existing social welfare and protection services for vulnerable children and families.

3. Country examples responding to children affected by HIV and AIDS

Some country examples of responses to children affected by HIV & AIDS are briefly described below:

- **Social cash transfer programme in Papua New Guinea:** Social cash transfer is part of a comprehensive national approach that seeks to empower female caregivers with children. It is geographically targeted to areas that have women and children with high vulnerability. Universally provided to female caregivers with children in these areas, it is considered a national priority with key national stakeholders and developmental partners involved in the design phase.
- **Policy framework of Henan in China:** The framework focuses on aid models, placement ways, and care and support methods. Aid models include cash transfers for living assistance, educational support and medical aid. Placement ways cover adoption, family foster care, simulation family parenting and agency foster care. Care and support methods involve psychological rehabilitation, skills training and community integration.
- **National Plan of Action for orphans, children affected by HIV and other vulnerable children in Cambodia:** The Plan is guided by the Convention on the Rights of the Child (CRC) and adopts the principles of gender equity, the involvement of children and a child-centred approach. Its strategies include the strengthening of family capacity to protect and care for orphans and vulnerable children (OVC), mobilizing and supporting community-based responses, ensuring access to essential services for OVC, enhancing the legal and policy frameworks for OVC, and creating a supportive environment for responding to OVC.
- **Community-based protection strategies for children affected by HIV in Myanmar:** In accordance with Myanmar's National Plan of Action for Children (2006-2015), the Child Protection Programmes are being implemented with the aim of strengthening family and community-based activities. These include capacity building of project staff and volunteers on community and home-based care for PLHIV, including children living with and affected by HIV; ensuring equal access to essential services; forming community support groups; community awareness-raising and community networking; and encouraging peer and community support to OVC through community self-help groups of PLHIV.
- **Family-centred care (FCC) approach in Viet Nam:** FCC is a set of systems and services that address the comprehensive needs of the whole family. It has five essential components: integrating paediatric HIV care and PMTCT into adult HIV clinics; establishing the role of FCC coordinators/case managers in assessing and supporting the psychosocial needs of families, children and caregivers; re-training community and home-based care teams to assess and respond to the needs of the whole family; linking clinical services with government, non-government and community-based organisations to provide social and economic support and child protection services; and advocating/developing skills on FCC.

4. Evidence-based approach – progress made since Hanoi

- **Regional estimation of monitoring and evaluation of response to children affected by HIV & AIDS:** The challenges for monitoring include the lack of leadership commitment and political will; poor coordination and management of M & E efforts; lack of a supportive environment for MARPs to access and use services freely; lack of harmonization in indicator definitions, data collection and analysis methods that negate data comparability; poor quality of coverage/service statistics; limited disaggregated data; and difficulty in the preparation of national population-size estimates for each risk group.
- **Impact assessment of HIV at the household level in Indonesia:** Among the key results of a comparative household survey of index (HIV-affected people) and reference (non-HIV affected people) are the following: Both groups had almost the same economic status (the majority of them are poor). More children in index than in reference have experienced hospitalization, higher anxiety and lower self-esteem and have engaged more in risky behaviour. The index have higher morbidity and are less likely to engage in sports, reading or to take part in religious group activities. They also feel more undermined and more harassed at school, have been refused care by health personnel and excluded by friends.
- **Needs assessment of HIV-affected and non-affected households in China:** Key findings from the household surveys of HIV-affected and non-affected households are as follows: HIV-affected, compared with non-affected households, have significantly lower income, higher health service utilization among children and more psychological problems (low self-esteem, limited social connection). On the other hand, there is no significant difference in enrollment for both groups.
- **HIVQUAL-T approach in Thailand:** This approach, adapted and implemented beginning in 2003, is an initiative for performance measurement, quality improvement and infrastructure development. Despite national guidelines, coverage for some key aspects of HIV care was low prior to quality improvement activities. On the other hand, hospital-based performance measurement data were effectively used, and benchmarking helped motivate hospitals to improve their quality of HIV care. The magnitude of the HIV epidemic and the complexity of treatment make quality assessment of HIV care essential. The approach has been successful in developing local capacity for quality improvement, including analysis of performance data and development of quality improvement initiatives.

5. Preventing infection among young people

- **Provider-initiated testing and counselling (PITC):** PITC targets the most-at-risk populations. The issues related to testing and counselling include third-party disclosure without client consent; lack of affordable VCT and PITC; absence of follow-ups and often insufficient assessment of risks; and inadequate screening of donated blood and related blood products that ensure the safety of blood supplies. To improve uptake of testing and counselling (T & C), it is important to encourage participation from targeted populations, addressing their needs and fears; include multi-sectoral support; expand public-private partnerships; ensure easy access to VCT services; and fund adequately the training and support of volunteer counsellors from affected populations as well as invest in counsellor training.
- **Youth prevention in Papua New Guinea:** PNG's prevention efforts aim to address collectively HIV & AIDS issues at young people. This includes training more counsellors and youth peer educators, ensuring that adolescents know their HIV status, understanding the quality of partnerships with stakeholders, mobilizing community resources and strengthening networking.

- **HIV prevention among young men in Viet Nam:** The sexual behaviour and drug use of young men are driving the HIV epidemic in Viet Nam. Attitudes toward gender norms are associated with HIV risk behaviours. As a response, a project was implemented to promote the adoption of risk-avoidance/risk-reduction practices among young men in Viet Nam; to improve their knowledge, attitudes and skills related to HIV prevention and gender; improve availability and accessibility to quality HIV-prevention information and services; and improve community support for healthy practices of young men.
- **Thai Youth Network:** The Network (Youth Net) seeks to enable children and youth to learn and understand HIV & AIDS and sexuality, to have access to services and to exercise their right to make their own decision about engaging in safe and responsible sex. It also aims to strengthen the capacity of youth networks on HIV & AIDS through sharing lessons learned on sexual health from each youth group. To achieve these aims, Youth Net recruits new youth leaders who are then taught to become informative HIV & AIDS facilitators. Youth Net also establishes new youth groups and links them with HIV & AIDS awareness groups and other youth development networks, and develops learning processes about HIV & AIDS and sexuality among youth groups in Thailand.

6. Preventing mother-to-child transmission and supporting paediatric treatment

This session focused on linked responses to scaling up PMTCT and paediatric AIDS care. A linked response aims to maximize service reach, access and uptake as well as improve health outcomes. Types of linkages are 'horizontal' – between HIV/STI, reproductive health (RH), and mother and child health (MCH) programmes, – and 'vertical' – primary health care links to specialist services. To effectively achieve outcomes, there is a need to improve data/information management and joint accountability of results. Among the key issues related to linked responses are the increase in the work load of existing health staff at health clinics and reproductive health services, conflict of interest and competition for resources, lack of political will from government units concerned, and poor leadership and management (as in the case of Cambodia).

Barriers to paediatric HIV care and treatment include the high cost of paediatric formulations, with the youngest children needing special formulations; the belief of many health professionals that only paediatricians can treat children; difficulty in ensuring ART adherence and in counselling children; limited availability of testing and treatment for paediatric HIV children; and children being lost to follow up. The Clinton Foundation, in addressing some of these barriers, has supported a number of projects/activities that provide technical, programme and logistical support (i.e. clinical training and mentoring, donation of paediatric ARVs, and laboratory assistance). In Thailand, a community-based HIV treatment and care initiative was introduced, implemented and scaled up in Chiang Rai province.

7. Partnership

- **Role and contribution of faith-based organizations:** Faith-based organizations (FBOs) have been involved in efforts to address the epidemic, particularly in developing novices and monks to serve as peer educators on HIV & AIDS and harm reduction; participating in multi-sectoral HIV prevention, care and support programmes; facilitating PLHIV networks, workshops and consultations; mobilizing faith communities and community care of orphans and vulnerable children through community care coalitions; and implementing child-focused, family-centred and community-based programmes. FBOs have acknowledged the need to establish a system for knowledge-sharing between them, develop clear guidelines on interfaith partnerships and establish a monitoring and evaluation system that will ensure evidence-based documentation and reporting. FBOs also want to be mainstreamed into national HIV & AIDS frameworks/strategies.

- **ASEAN commitments on HIV & AIDS:** The ASEAN regional response to HIV & AIDS includes the establishment of the ASEAN Task Force on AIDS (1992), the development of ASEAN Work Programmes on HIV & AIDS (1995-2000, 2002-2005, and 2006-2010) and the Vientiane Action Programme (2004-2010). ASEAN held the 7th ASEAN Special Session on HIV & AIDS (December 2001 in Brunei Darussalam) as well as the 12th ASEAN Summit Special Session on HIV & AIDS (January 2007 in the Philippines). The ASEAN Secretariat seeks to commence initiatives within ASEAN member states to support PMTCT and to integrate gender-responsiveness strategies into general HIV-prevention policies and programmes.

The Regional Partnership Forum was graced with a performance by the 'We Understand Group' that works with children infected by HIV in Thailand. In a multimedia dance and art performance, the children expressed their pain, fears, hopes and desires for their future while living with HIV. Art is a form of therapeutic expression for the children. They told delegates that adults should be honest with children about their status and that children living with HIV need encouragement and support.

Consolidated group outputs

Some common themes emerged from the group output presentations. There was a lot of progress but not enough. Problems with definitions and terminology persist. Groups spent a lot of time discussing ways to link the 4 Ps', some into government programmes and policies. Stigma and discrimination were persistent problems mentioned by all groups. PLHIV involvement is needed, especially in work done at the community level. Funding uncertainty and sustainability is also an issue. Lack of resources, harmonization and capacity were brought up by all groups.

Priority actions include scaling up PMTCT; reducing stigma and discrimination; increasing access to the 4 Ps for children from the most-at-risk populations; promoting and strengthening alternative care options; strengthening multi-sectoral coordination; strengthening M&E tools, data collection and analysis; increasing resources through donor commitments; and increasing funding of ministries responsible for the response.

Day One: 31 March 2008

Introduction

Welcome remarks



Anupama Rao Singh

Regional Director, UNICEF East Asia and Pacific Regional Office

“More women and children will be living with HIV if we allow our commitment to slide.”

Ms. Singh began by noting the value of multi-partner collaboration in addressing the social, economic and health impact of HIV and AIDS, particularly among children and women, who remain the missing faces of AIDS in the region. She expressed hope that participants would reconfirm their

commitment to partnership and to prioritize resources and energies not only for the most-at-risk populations but also for their partners and children and for those who are living with HIV.

She explained that the main focus of the three-day Forum was to review the progress of the commitment made in key areas of action since the March 2006 Regional Consultation on Children and AIDS in Hanoi, Viet Nam. Ms. Singh identified nine priority areas of action:

1. Building knowledge on and undertaking assessments of the situation of children affected by AIDS, taking into account the differences in priorities and responses (policy, programme, services) among countries in the region;
2. Ensuring that legislation, policy and guidelines are updated to protect, support and care for these children who may drop out of school, may go hungry, lack parental care and are vulnerable to abuse and exploitation;
3. Scaling up the critical responses, particularly the “4 Ps”;
4. Mobilizing adequate resources and improving their allocation;
5. Strengthening multi-sectoral responses at the national level, including the involvement of the public sector, civil society, religious leaders and children and young people;
6. Reinforcing measures to reduce stigma and discrimination;
7. Expanding efforts to protect children and providing them with the most family-like care environment possible;
8. Ensuring that proper monitoring systems are in place to provide the information needed to assess the effectiveness of programmes and services and adapting them to meet evolving situations; and
9. Strengthening collaboration and coordination at the regional and international levels to maintain a collective commitment and to enhance collective learning, which has proven very fruitful and highly critical.

Furthermore, the Forum was in support of discussing how better to protect children and how to reduce the impact of AIDS on children. It was also for addressing the factors that exacerbate vulnerabilities that put children at risk. In covering these issues, the Forum should reveal whether:

- the current social protection policies, programmes and systems are adequate;
- parents’ survival is assured with long-term antiretroviral treatment and care;

- children exposed to HIV are getting tested and treated;
- pregnant women and their parents are adequately informed about prevention measures and HIV transmission risks;
- parents, young adults and adolescents who are at risk know how to protect themselves; and
- testing and counselling services are widely available, confidential and optional.

Opening speeches



J.V.R. Prasada Rao

Director, UNAIDS Regional Support Team for Asia and the Pacific

“Meagre resources are utilized for programmes with minimum effectiveness when it comes to preventing new infections”

Mr. Rao shared information on the recent launch by the United Nations Secretary General, Mr. Ban Ki-moon, of a report on AIDS in Asia prepared by an independent commission on AIDS in Asia. Mr. Ki-moon had called upon all Asian countries to better their understanding of the Asian epidemic and mount an effective response that can halt and reverse the epidemic in Asia. Also he urged them to put their money to best use by investing in programmes that are effective and can bring down the number of new infections and to launch impact mitigation programmes for women and orphaned children, which, even after 25 years into the epidemic, are notably absent in national programmes in most of the countries. Mr. Rao appealed to all delegates to take a serious look at the findings and the recommendations of this report, now available on the UNAIDS website with free copies obtainable from the UNAIDS Regional Support Team.

Mr. Rao noted that the current level of response to HIV and AIDS is nowhere near optimal levels. In terms of resources, about \$ 1.2 billion per annum has been reached, which falls short of the UNAIDS estimated minimum \$3 billion to halt and reverse the epidemic. Even these meagre resources are utilized for programmes with minimum effectiveness for the prevention of new infections. Care and impact mitigation programmes are reaching a very small section of the populations who are in need of them.

Based on the 2007 analysis of the UNGASS country reports, three important indicators were found to have a bearing on prevention and care programmes for children:

1. PMTCT coverage, which continues to be below 10 per cent in nearly all countries except Thailand and Malaysia;
2. Paediatric treatment, which continues to be low, with only about 20 per cent of children who need antiretroviral therapy (ART) currently getting it and nearly all of these children are from three countries: Cambodia, Thailand and India. The levels of knowledge and awareness among young people have increased in the past five years but are still quite low, i.e. below 40 per cent in most countries; and
3. Prevention took less than 50 per cent of the resources spent in most of the countries. Less than 30 per cent of prevention money is going to priority programmes including PMTCT.

To achieve Universal Access targets by 2010, Mr. Rao cited the need:

- To switch gears for faster and wider coverage of services focusing on prevention activities, providing treatment and mitigating the impact on women and children;
- For country programmes, the UN system and civil society partners and donors to take responsibility for helping countries scale up priority programmes;

- To ensure a larger availability of funds from donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM);
- To submit convincing proposals for funding PMTCT and impact mitigation programmes for children in the next round of funding from GFATM, which has the largest financial commitment, at \$US 2 billion for AIDS, tuberculosis and malaria programmes; and
- For the UN system to provide necessary technical support to countries to prepare and submit proposals that meet the rigorous quality standards of GFATM and to produce more credible and disaggregated data for use by countries to ensure the availability of adequate resources for programmes.



Jimmy Kolker

Chief, HIV and AIDS, UNICEF New York

“Prevention requires knowledge. In this region, knowledge is disturbingly low.”

Mr. Kolker provided a brief background and stated the objectives of the 2006 Regional Consultation on Children and HIV & AIDS and the 2008 Regional Partnership Forum.

He presented data from UNAIDS Asia-Pacific 2007 Epi Update as follows:

- An estimated 4.9 million people were living with HIV in 2007 (down from 8.3 million estimated in 2006), including 440,000 newly infected. Approximately 300,000 died from AIDS-related illnesses in 2007.
- Globally, the number of children living with HIV increased from an estimated 1.5 million in 2001 to 2.5 million in 2007. However, estimated new infections among children declined from 460,000 in 2001 to 420,000 in 2007. Nearly 90 per cent of all HIV-positive children live in sub-Saharan Africa.
- The estimated number of people living with HIV in Viet Nam has more than doubled between 2000 and 2005 (from 120,000 to 260,000), but Indonesia has the fastest growing epidemic. In Indonesia's Papua province (bordering Papua New Guinea), HIV prevalence among 15-24-year-olds has reached 3 per cent.
- Feminization of AIDS: In Asia, the proportion reached 29 per cent in 2007. An estimated one third of people living with HIV in Viet Nam in 2006 were women. In Thailand, more than four in ten (43 per cent) of all new infections in 2005 were among women.
- Declines in new HIV infections: Cambodia, Myanmar and Thailand.

PMTCT

- About 1.5 million HIV-positive women gave birth in 2006 in low and middle income countries. Of those women, 23 per cent were treated to prevent transmission to their child.
- There was a 60 per cent increase in the number of pregnant women with HIV who were receiving ARV prophylaxis for PMTCT in low- and middle income countries in 2006 from 2005.
- More than 100 countries have established national PMTCT programmes.
- Thailand, Fiji, Pakistan and Malaysia in Asia-Pacific are already meeting the UNGASS target of 80 per cent access to PMTCT coverage by 2010.

Day One: Introduction

- Reductions in MTCT occur through essential actions such as:
 - primary prevention among women of child-bearing age
 - reducing the number of HIV-positive women who become pregnant
 - identifying HIV-infected pregnant women through routine offers of testing in high-prevalence areas
 - enrolling HIV-positive pregnant women in PMTCT programmes
 - ensuring health systems are able to deliver effective ARV regimens
 - supporting women in providing optimal, safe infant feeding
 - minimizing loss to follow up to detect HIV status of newborns.

Paediatric Treatment

- 127,300 children received ART in 2006 compared to 75,000 in 2005 – up 70 per cent.
- 93.5 per cent of children in Cambodia, 96 per cent in PNG and 93 per cent in Viet Nam are known to be alive after 12 months of initiation of antiretroviral therapy.
- A recent study in South Africa found that mortality was reduced by 5 per cent in HIV-infected infants who were treated before they reached 12 weeks of age.
- Cambodia has revived the good practice of paediatric care service through paediatric HIV treatment.
- Thailand's HIVQUAL helps to enhance quality of services, follow ups and scale up.

Prevention of infection among adolescents and young people

- In several countries, behaviour change has translated into declining HIV prevalence among young people.
- HIV prevalence among young pregnant women aged 15–24 attending ante-natal care has declined in 11 of 15 countries with sufficient data.
- In more than 70 countries surveyed, testing and the use of counselling services increased from roughly 4 million people in 2001 to 16.5 million in 2005.
- The emphasis of prevention responses is refocusing strategies on adolescents and young people most at risk.
- Globally, countries are still far from on track to reach the target. We need examples of effective messaging and how to tailor messages to the young people getting infected.
- Prevention with positives is essential. Every sexual transmission of HIV is in a discordant couple.
- Young people aged 15–24 accounted for about 40 per cent of new HIV infections in 2007.

Protection and support

- 133 million children globally have lost one or both parents due to all causes, including AIDS, as of 2005.
- In low and concentrated epidemics, only a small proportion of children are affected by AIDS – estimated 1.5 million in Asia-Pacific – but these children are particularly likely to face discrimination, especially where parents are already stigmatized due to AIDS.
- Emerging evidence shows children affected by AIDS are likely to repeat parental behaviours and risk becoming the next generation of MARPs due to lack of parental guidance, bonding and security and deprivation of basic rights and opportunities.
- Disparity between orphans and non-orphans in access to education is being reduced in several countries.
- Social protection, including child grants and other benefits on a national scale, is being introduced or improved in all regions.
- Children and their needs need to be more integrated into national policy frameworks, HIV & AIDS plans of action and poverty-reduction strategy.

Mr. Kolker notes that to scale up the 4 Ps in East Asia and Pacific, it is necessary to:

1. Link the 4 Ps around local epidemics;
2. Improve the continuum of prevention, care, treatment and support and increase access to all essential services;

3. Improve evidence-based approaches; and
4. Mobilize resources.

In putting children first, it is crucial to strengthen communities and families; to integrate interventions to support children affected by HIV and AIDS in strong health, education and social welfare systems, which include operational linkages within the health system itself, between HIV, STI, reproductive health and MCH; and to find measurements that demonstrate progress and gaps.



Cathy Bowes, Director

Office of Public Health, U.S. Agency for International Development,
Regional Development Mission/Asia

“The challenge is how to reach most-at-risk children.”

Ms. Bowes provided background on what the U.S. Government does to combat HIV and AIDS. She said that the U.S. Government is committed to improving the lives of children vulnerable to, infected and affected by HIV/AIDS. The heart of the U.S. President’s HIV/AIDS emergency plan is to work shoulder to shoulder with partners in

host nations in support of the national strategy in each country.

The U.S Government has a long history of addressing orphans and vulnerable children’s needs in Asia. The Displaced Children and Orphans fund, a U.S Agency for International Development Program, was established in 1989 and has provided more than \$160 million in support in over 40 countries. It continues today by increasing access to social services, improving quality of national standards, promoting social and economic integration of orphans and vulnerable children and strengthening the capacity of families and communities in working with these children.

In January 2003, President Bush announced the creation of the Presidential Emergency Plan for AIDS Relief (PEPFAR) to fight HIV and AIDS. In Asia, the Emergency Plan has been implemented in Cambodia, China, India, Indonesia, Laos PDR, Myanmar, Nepal, Pakistan, Papua New Guinea, the Philippines and Viet Nam. PEPFAR pays considerable attention to children 14 years of age and younger. In 2007, it treated 86,000 children through paediatric AIDS interventions, a 77 per cent increase over the number of children PEPFAR-supported treatment in 2006. It also supported the training or retraining of approximately 214,900 individuals in the 15 focus countries to care for orphans and vulnerable children. Funding for treatment and care services for orphans and vulnerable children totalled more than \$289 million in these countries.

Under the Emergency Plan, the U.S Government supports the following services:

1. Advocacy and social mobilization to create a supportive environment and reduce stigma and discrimination for children affected by HIV/AIDS;
2. Helping OVCs acquire the skills and knowledge to protect themselves from HIV infection, including providing life-saving prevention education to out-of-school youth;
3. Therapeutic, economic, psychosocial, and other risk-reduction support to OVC, their families and caregivers;
4. Working with governments to protect the most vulnerable children through improved legislation and by channelling resources to communities; and
5. Helping OVCs’ access to education, vocational training, health care with registration, legal services and other resources.

However despite the strides many challenges remain as follows:

- Treatment to prevent mother-to-child transmission can reduce by 50 per cent the number of children acquiring HIV from their mothers, yet worldwide, less than 10 per cent of HIV-positive women benefit from PMTCT services.
- In most countries OVCs are the responsibility of poorly resourced ministries, but OVCs are often perceived as an increased burden to communities already stressed by many other factors, including HIV and AIDS. Furthermore, there is the complex nature of OVC programmes – children have many needs, and specifically in Asia, there is the question of how to reach most-at-risk children that are stigmatized, such as the children of people in prostitution, IDUs and PLWHAs. Another issue is how to link families with a complete continuum of care, treatment and prevention where no continuum exists.

Ms. Bowes said that in meeting these challenges it takes leadership and coordination, including supporting the relevant ministries working with the GFATM on OVC issues, training leaders on OVC issues and advocacy for this vulnerable group, and teaming with other international organizations to advocate, coordinate and support strong leadership.



David Claussenius

Asia Regional Director, Save the Children, USA

“Partnerships are a critical component for success.”

Mr. Claussenius said that it can never be enough simply to ensure that the needs of children and young people in relation to HIV & AIDS are placed on an ‘agenda’. It is also imperative that we translate that commitment into action by urgently and ambitiously scaling up our responses based on programmes that have proven to be effective and which reflect the region’s epidemiological and cultural realities. A key challenge, for example, is finding feasible and non-stigmatizing approaches to providing the care, support and protection that children affected by HIV & AIDS so critically require.

He proceeded to share the specific roles and contributions of Save the Children in HIV & AIDS prevention, mitigation, and care programmes that have been undertaken since 1991 in South and Southeast Asia and the Pacific Region. Save the Children supports programmes in 15 countries with help from GFATM, bilateral donors (including AusAID, USAID, DfID), foundations (Gates) and private donors over the past 15 years. Save the Children has a long history of working directly with communities, mobilizing resources and building their capacities. Its programmes reach youth (especially those at greater risk) and children affected by HIV & AIDS and their families – and, critically, the various gatekeepers who must be engaged in Save the Children’s efforts.

Mr. Claussenius pointed to the importance of open and collaborative partnerships in meeting the enormous need and of crafting the variety of responses demanded within the region. According to him, Save the Children and its partners contribute to the four pillars of the Global Campaign on a daily basis throughout the region.

- **Protection and care of children affected by HIV and AIDS:** Save the Children works with the Government of Viet Nam and local organizations to develop participatory child protection systems that include the provision of HIV and AIDS prevention, care and support. In Cambodia, Save the Children and UNICEF train Buddhist monks, lay people and

community volunteers in providing psycho-social support for children and their families affected by HIV. In Indonesia, Save the Children integrated HIV and AIDS programmes into the post-tsunami response works with partners to promote the mainstreaming of HIV issues into child-protection work throughout the country.

- **Prevention of infection among adolescents and young people:** As the risk of HIV infection increases among youth in Viet Nam, Save the Children, in partnership with government agencies, seeks to reach 70,000 at-risk young men in street-based settings, vocational schools and universities. In Myanmar and China, the spread of HIV & AIDS among most-at-risk youth is being addressed by providing peer counselling and education and increasing access to youth-friendly health services. Similarly, building on adolescent-friendly health services in the Philippines, Save the Children is training health service providers in the provision of youth-friendly VCT.
- **PMTCT is being innovatively scaled up in Myanmar:** In collaboration with the National AIDS Program of Myanmar, the Department of Health, and UNICEF through a community-based programme integrating PMTCT with essential reproductive health care to strengthen public sector services and build local capacity. This model has gained national-level interest, and Save the Children is working with other agencies to develop proposals to take this work to greater scale, thereby benefiting larger numbers of women, their partners and families. Also in Myanmar, Save the Children leads the Myanmar NGO Consortium on HIV/AIDS, designed to improve the continuum of HIV prevention, treatment and care including those children living with and affected by HIV & AIDS.

Mr. Claussenius said that none of the above-mentioned work can be achieved without a commitment to work through the challenges and complexities of partnerships. These partnerships, however, bring the benefits of added strengths, expertise and resources. Finally, and importantly, he said that partnerships should also include children and young people. It is critical not only to hear their voices but also to engage them in the response. They have much to contribute, including identifying relevant solutions to their challenges and experiences.

Keynote address



H.E. Mr. Anand Panyarachun

former Prime Minister and UNICEF Goodwill Ambassador for Thailand

“Those living with HIV no longer need to be doomed to lives of illness, alienation and penury.”

Mr. Panyarachun cited some global statistics on HIV and AIDS: globally, it is estimated that 2.3 million children under 15 years of age are infected with HIV and that more than 12 million have lost one or both parents to the disease. Though the estimated number of affected children in this region is comparatively small, given the region’s generally low prevalence rates, the reality is that we do not quite know the full picture due to massive underreporting.

According to Mr. Panyarachun, children affected by HIV and AIDS in this region experience too many losses too early in life, including the loss of parents, loss of security and the overall

well-being of their family, loss of effective access to education and other essential services, and the loss of dignity due to stigma and discrimination. Many of these children also face the danger of repeating the perilous journeys of their parents, adopting risky behaviours out of a pressing need for survival, for want of care-givers' guidance or due to despair and the lack of hope and opportunities for the future.

Yet with improved public knowledge and understanding of the epidemic and improved access to antiretroviral drugs, children affected by AIDS and those living with HIV no longer need to be doomed to lives of illness, alienation and penury. They can be free from a deprivation of parental care and chronic illnesses. They can attend school. They can have families and communities that love and care for them. They can, in short, grow up just like other children. However, major gaps still exist between these possibilities and the realities, and we must close these gaps at all costs.

Mr. Panyarachun noted the recent decline in HIV prevalence in Cambodia and Myanmar and talked about the experiences of Thailand. According to him, the number of new HIV infections in Thailand has fallen drastically, from a high of 143,000 in 1991 to 14,000 in 2007. And for those living with HIV, there is now greater access to antiretroviral drugs.

When he became Prime Minister in 1991, HIV was rampant throughout the country, the number of new infections at its peak. Sentinel monitoring of infection levels in all provinces indicated that the HIV prevalence had jumped five-fold within a two-year period. It was predicted that over the next 20 years, up to 10 per cent of Thais would die from AIDS. Thailand was on the verge of a major social crisis. The traditional and punitive public health measures that had been practised to combat the epidemic up until that time clearly were not working.

In order to confront the challenges of the HIV epidemic, the Thai people had to confront their own mindset and own denial of reality. They had to accept that the epidemic was being driven by socio-cultural practices, which at that time no government wanted to admit existed. These included commercial sex, intravenous drug use and cultural practices such as the sale of children and young women into sex work. The fact that all these activities are illegal makes people want to deny their existence. Not only did they have to accept the existence of these practices, but also they had to accept that they occurred on a large scale in Thai society. For example, over 20 per cent of Thai men were visiting sex workers every year. It was therefore necessary to publicly acknowledge the scale of the challenge of HIV and to state that the Government was going to take urgent action to reduce its spread.

The highest political leadership was needed to effectively address HIV and AIDS. Mr. Panyarachun, as then Prime Minister, established and chaired the National Aids Prevention and Control Committee under the Office of the Prime Minister. This committee became the coordinating body for national planning and public education on HIV and AIDS. To mount a national-scale programme, the Thailand Government had to quickly and drastically increase the government budget for HIV and AIDS rather than wait for help from foreign donors. The government AIDS budget for prevention and control was increased by over 9 times, from \$2.6 million in 1990 to \$24 million in 1992. After he left office, the budget increases continued under succeeding governments. In 1993, the government budget for HIV and AIDS went up to \$46 million and in 1996 to over \$80 million. These sums did not include aid from donors. It was definitely not "business as usual" in Thailand.

Backed by these resources, an unprecedented public information campaign on AIDS was launched. The Government of Thailand recognized the necessity of educating the whole of Thai society, not just those groups at highest risk. It was fighting for radical change in perception and

a behavioural change within Thai society. The Government mounted a nationwide education and preventive campaign that enlisted the co-operation of all media. Safe sex and HIV messages were aired every hour on more than 500 radio stations and seven television stations. Ensuring that everyone received HIV & AIDS information was critical. At the time, however, the tourism industry was seriously concerned about the possible negative impact of such a public education campaign on tourism. To balance the need to promote public health education with the need to increase tourism, political commitment at the highest level proved crucial allowing the information campaign to proceed.

The Thai Government also targeted parents and teachers, many of whom still had conservative attitudes. It initiated a national programme on HIV/AIDS education in schools and mounted a large-scale peer education programme for young people in the workplace. It also promoted prevention interventions among drug users, the majority of whom were young people. It targeted sex work and established the “100 per cent Condom Programme”, which enlisted the co-operation of agencies and individuals to distribute free condoms to clients of sexual services. At the same time, it took effective measures to ensure the high quality of condoms on sale.

Very early on, the Government fought stigma and discrimination in order to protect the rights of people living with HIV and AIDS. When Mr. Panyarachun took office as Prime Minister, there was a proposal to pass legislation that would have restricted the rights of people living with HIV and AIDS. He did not allow this bill to pass. There were prevention campaigns that inadvertently reinforced the stigmatization of people living with HIV and AIDS. Thus, the Government stopped those campaigns. It also lifted the ban on entry to Thailand of foreign nationals known to have HIV and AIDS.

The subsequent development and the overall decline in HIV prevalence in Thailand validated the approach the Government took in the early 1990s. Similar efforts were made in other countries in the world, and it was through such efforts that the course of the epidemic was changed.

The challenge being faced now both in Thailand and elsewhere is how to sustain the commitment made and the momentum generated over recent years. It is also clear that as the AIDS epidemic grows and matures, the number of children affected will increase. A child-centred approach to AIDS is vital, and this calls for strong policy measures and programmes to protect children from multiple vulnerabilities and the likelihood of them repeating their parents’ journey and to become the next generation of those most at risk of contracting HIV. It also calls for the empowerment of families and communities and the improvement of operational linkages within the health system and between the health, education and social support systems – all to foster the continuum of HIV prevention, treatment and care services. Experience in Thailand has shown that the HIV epidemic is constantly evolving. Approaches and responses to HIV must also be ever-evolving to meet the new challenges.

Mr. Panyarachun said that there is never room for complacency. Despite positive developments in many countries, the situation that we face continues to be alarming. In 2007, there were almost 20 per cent more new HIV infections in East Asia than in 2001. Despite the remarkable efforts made in scaling up HIV responses, children remain the “missing faces.” There is an urgent need to mobilize the political will and additional resources required to respond to this troubling increase in infections.

Session 1.

National responses following Hanoi



Viet Nam
Dr. Nguyen Trong An
Deputy Director, Children Care and Protection Department
Ministry of Labor, Invalids and Social Affairs

Dr. Trong An's presentation focused on basic statistics for the HIV epidemic in Viet Nam, the national response to HIV and AIDS, and the drafting process and contents of the National Plan of Action (NPA) on Children and HIV and AIDS.

The HIV epidemic in Viet Nam is still in the concentrated phase, with prevalence estimated at 0.53 per cent among the general population, 23.2 per cent among male injecting drug users, 9 per cent among men having sex with men, 4 per cent among female sex workers, 0.37 per cent among pregnant women, and 0.3 per cent among young people aged 15-24 years. An estimated 8,500 children are infected with HIV, but only 789 are receiving ART. A 2003 survey estimated that 280,000 children are affected by HIV and AIDS in Viet Nam.

Specifically addressing the situation of children and HIV and AIDS, Viet Nam has completed five assessments. These are on:

- Orphans and other vulnerable children;
- Children's forums;
- Vulnerability to HIV of children in institutions;
- Operational barriers to implementation of social policy, with a focus on alternative care for OVC; and
- A national situation analysis of children affected by HIV and AIDS.

It also applied the Estimation and Projection Package (EPP) and Spectrum technologies and is currently undertaking research on street children and HIV, a national survey on vulnerable children including those affected by HIV and AIDS, and a national assessment of community- and home-based care needs of HIV-affected families and children. It will review data

collection tools in the health, education and social welfare sector in the context of the NPA for children and HIV & AIDS.

In addressing the needs of children affected by HIV and AIDS, seven country-specific action plans were approved and promulgated in the following areas: care and treatment; PMTCT; IEC/BCC; reproductive health (RH) and HIV in secondary schools; harm reduction; STI management and coordination. The evidence-based NPA on Children and HIV and AIDS is now in its final stage of completion. Other initiatives include revision, adoption and promulgation of law on HIV and AIDS control and prevention; revision of national ART, palliative care, PMTCT and OST guidelines; issuance of guidance documents to improve the implementation of policy on alternative care and increase social gains; evaluation of a significant number of small-scale initiatives and pilots providing social services for OVCs for scale up in the context of the NPA on children and HIV and AIDS; and the development of a participatory interventions package to address stigma and discrimination (S&D) in the health care system and schools.

In terms of national coordination mechanisms and resource mobilization, Dr. Trong An said that there is already an approved action plan for and active coordination between the Government and the international community. Also, there is a multi-sector national Government coordination forum for the drafting of the NPA on Children and HIV & AIDS. Another positive gain is the rising level of resources for HIV; however, data could not be segregated by target and/or age group.

The NPA on Children and HIV and AIDS is a prime-ministerial decree, the final draft of which is ready for approval in April of this year. The key ministries involved were the Ministry of Labor, Invalids and Social Affairs, the Ministry of Health, and the Ministry of Education. The drafting process was multi-sectoral, participatory and evidence-based, with active support from the international community and from people living with HIV. The NPA targets orphans and other vulnerable children, including children most at risk for HIV infection. It covers the period 2008-2020 and aims to:

1. Improve mechanisms to assess and respond comprehensively to the needs of children affected by HIV and AIDS;
2. Improve accessibility of basic social services to which children and their caregivers are legally entitled;



Cambodia
H.E. Dr. Teng Kunthy
 Secretary General
 National AIDS Authority

Dr. Kunthy's presentation was divided into four main parts:

1. An overview of the HIV situation in Cambodia
2. Specific actions taken since the Hanoi Consultation
3. Challenges
4. Way forward or next steps

In June 2007, HIV prevalence in Cambodia among adults aged 15-49 was 0.9 per cent, down from a peak of 2 per cent in 1996. HIV prevalence among pregnant women is at 1.1 per cent. As of 2006, the number of children living with HIV was estimated at 9,000 while those newly infected through vertical transmission was 1,550 each year (without PMTCT). The Cambodia Demographic and Health Survey (CDHS) 2005 survey reported a 0.1 per cent HIV prevalence among boys aged 15-19 years.

Some general actions that focused on children included the establishment of a National Multi-sectoral OVC Task Force in 2006; revision of

3. Ensure that services specifically required by children affected by HIV and AIDS are available and child-oriented;
4. Create an enabling social environment to protect, care and support children affected by HIV and AIDS; and
5. Improve monitoring and evaluation mechanisms to obtain data that informs policy and programming for children affected by HIV and AIDS.

Dr. Trong An listed the anticipated actions after NPA approval: a detailed implementation plan for 2008-2010 with budget and potential funding source to facilitate rapid start of implementation; launching of NPA nationally and in key provinces; and a review of NPA in 2010 in light of the anticipated approval of the draft overall child protection strategy.

the National Strategic Plan 2006-2010; development of national monitoring and evaluation guidelines; audit of policy; and the preparation of HIV research agenda.

For PMTCT, the Ministry of Health, through national mother and child health centres (NMCHC), did a national review of services, prepared a national PMTCT expansion plan for 2008-2015, advocated for PMTCT through the Joint Ministry for 2008 and expanded services to 98 health centres and 57 Reproductive Health Centres as of December 2007.

For paediatric AIDS care, the National Center for HIV & AIDS, Dermatology and Sexually Transmitted Diseases (NCHADS) expanded to 23 facilities, reaching 2,541 children with ART, which comprised 84.5 per cent as of December 2007. Also, it expanded the adult ART programme to 46 facilities, reaching 24,123 adults (51 per cent women and covering 80 per cent) during the same period.

For prevention of infections among adolescents and young people, the Ministry of Education, Youth and Sport developed and costed a Strategic Plan for HIV (2008-2012), which incorporates four strategies including one that seeks to increase coverage and quality of HIV education for children and youth who are especially vulnerable and at higher risk. The Ministry of Women's Affairs likewise developed and costed a Strategic Plan on Women, the Girl Child and HIV & AIDS (2008-2012), which includes five strategies including one that promotes family values and social cohesion as well as partner communication to reduce vulnerability.

For protection and support of children affected by HIV, the Ministry of Social Affairs, Veterans and Youth Rehabilitation had developed a policy and database on alternative care in 2006; conducted a participatory OVC situation and response analysis, developed and costed the National Plan of Action for Orphans, Children Affected by HIV and Other Vulnerable Children (2008-2010); developed minimum standards for residential care and community-based care; mapped out service providers for community-based care; and successfully applied to GFATM Round 7 with a component on OVC.



China
Dr. Han Meng Jie
Deputy Director
National Center for AIDS/STD Control and Prevention

Dr. Meng Jie provided an overview of the epidemic in China, shared some successes in scaling up HIV interventions, and described the next steps for scale-up to achieve Universal Access.

By the end of October 2007, China had 223,501 reported cumulative cases, including 62,838 people with AIDS and 22,205 deaths. Of these cases, 71.3 per cent were males while 28.3 per cent were females. Seventy per cent was concentrated among the 20-39 age group. By

For partnerships, the National AIDS Authority articulated child-related issues in the Universal Access commitment documents and integrated OVC issues into Commune Investment Plans. The Ministry of Cults and Religion continues to implement the 2002 national policy response to HIV and developed a national guideline for pagodas to address the needs of OVC.

Among the challenges in implementing the actions mentioned above were finding a balance between a vertical approach and an integrated one, in shifting focus from policy development to policy implementation, in scaling up impact mitigation interventions with emphasis on sustainability and reducing dependency, and in further mobilizing resources.

As to the next steps, there is a need to accelerate the expansion of PMTCT services and use the opportunity to strengthen overall maternal and child health services; increase the emphasis on prevention with high priority to MARPs, many of whom are also adolescents; further scale up care and treatment services with growing emphasis on quality; and mainstream and decentralize HIV programme implementation through the Commune Investment Plans and Fund.

the end of 2007, the number of people living with HIV was estimated at 700,000 while new infections accounted for 50,000, in which heterosexual transmission was 44.7 per cent, homosexual transmission was 12.2 per cent, IDU transmission was 42 per cent, and mother-to-child transmission (MTCT) was 1.1 per cent.

The cumulative number of youth aged 0-19 was 4.6 per cent of the total cumulative HIV cases. There were 8,644 reported double

orphans in 127 China CARES counties. The number of children infected with HIV through MTCT was estimated at 500-600 in 2007.

On strengthening leadership and partnership, the following were achieved: increased financial support – from RMB 854 million in 2006 to 944 million in 2007; and the growing involvement of mass organizations and community-based groups (including women) in HIV and AIDS responses. Also, national leaders continuously set examples of supporting children affected by AIDS through personal actions.

On prevention of HIV among young people, the following were undertaken: launching the 'Chinese Campaign on HIV Prevention among Children and Youth' jointly with eight government ministries and mass organizations in September 2006; involving more than 200,000 youth in the Face-to-Face communication campaign that reached 3.2 million youth through the Internet; joint-launching of the Plan for University Students on Communication for AIDS Prevention and the training of communication volunteers from 15 provinces; disseminating various key messages and materials on HIV for children and youth; training of more than 10,000 teachers on HIV; establishing a youth ambassador network with more than 200 youth ambassadors across the country; and an online quiz on HIV awareness for young people, which had more than 18 million visitors.

On protection of children and families affected by AIDS, 15 Ministries jointly issued the policy to provide nine areas of support to all orphans including children orphaned by AIDS. The amount of RMB 35 million was allocated for the education and living allowances of children affected by AIDS. Other forms of assistance provided were life assistance for 20,879 PLWHA; self-support activities for 6,255 people; family support and schooling for 90

per cent of the reported children orphaned by AIDS; and '2 frees and 1' subsidy for 3,167 orphans (or 93% of the total of school-aged children). A number of policies have been developed since 2004 that provide education, health and financial support to children affected by HIV and AIDS. Also, provincial support mechanisms were developed. Various placement models were set up to provide care options for orphans. In Henan province, a comprehensive protection and welfare system for children was developed and piloted, as well as discussed during an international consultation held in China.

On PMTCT and paediatric AIDS treatment, care and support, the following were achieved: the PMTCT programme covered more than 2.65 million pregnant women in 271 counties within 31 provinces (as of October 2007). Of these, 77.7 per cent received AIDS counselling while the testing rate was 74 per cent. In terms of antiretroviral treatment, 72.4 per cent received ARV drugs while the rate of ARV treatment for babies was 80.4 per cent. MTCT decreased by nearly 60 per cent through prevention measures. ARV treatment was provided in 1,190 counties of 31 provinces; 39,289 AIDS patients (>15 years old) received ART while 31,849 remain on treatment. Paediatric ARV treatment covered 141 counties and 22 provinces, with 805 who received ART and 761 remain on treatment.

Dr. Meng Jie enumerated the following steps needed for scaling up activities to achieve Universal Access: implement strategic communication in order to improve attitudes toward people affected by AIDS; improve service and information systems to identify HIV-positive children early and start appropriate treatments; scale up PMTCT; improve comprehensive protection, care, support and treatment mechanisms for children affected by AIDS; and strengthen capability of the local response team.



Lao PDR
Dr. Chansy Phimpachanh
Director of Center for HIV/AIDS/STI
Ministry of Health

Dr. Phimpachanh provided some statistics on the HIV situation in Lao PDR. HIV prevalence among sex workers was 2 per cent in 2004. The estimated numbers of cumulative HIV cases from 1990 to 2007 were: 2,630 HIV positive; 1,675 with AIDS; 820 AIDS deaths; and 135 (>14 years old) HIV-positive children. The mode of HIV transmission has been largely heterosexual sex (85 per cent), followed by MTCT (3.5 per cent), homosexual sex (0.7 per cent), blood transfusion (0.3 per cent), and needles (0.2 per cent). However, there is a 10.3 per cent under-reporting of HIV cases.

In terms of country response, Lao PDR developed the 2006-2010 HIV/AIDS National Strategy and Action Plan that integrates a life-skills curriculum with HIV/AIDS/STI/drug use issues. It also trained teachers to reach school children and adolescents. Furthermore, it established a national taskforce on PMTCT and paediatric AIDS as well as developed a legal and policy framework.

Following the 2006 Hanoi Consultation, the following initiatives/activities were undertaken: a needs assessment of children and adolescents affected by HIV/AIDS done in late 2006; the passage of a Law on the Protection of Rights and Interests of Children by the National Assembly in 2007; provision of life-skills education to 70 per cent of total lower and upper secondary school students; availability of ARV treatment in two provinces and a scale up to three more sites with GFATM support;

increase in psycho-social support to self-help groups of PLHIV including children from three to seven provinces; promotion by the Lao Buddhist Initiative of Buddhist compassion and stigma reduction through campaign and outreach activities in five provinces; development of a National Guideline on PMTCT with a focus on primary prevention, integrating into mother and child health clinics; development of institutional capacity for paediatric AIDS through workshops and on the job training; development of a model for community care and support to address access to basic education and health care, and provision of social support; availability of ARV treatment for HIV-positive pregnant mothers to prevent MTCT; and antenatal care (ANC) surveillance in three central hospitals in Vientiane to determine HIV prevalence.

Lao PDR still faces several challenges including an increase in HIV infections transmitted from mothers to children, limited ARV treatment sites, limited funding, late diagnosis of PLHIV, and a limited capacity of care providers at the local level. The country plans to advocate for Universal Access through a multi-sectoral response, establish a national monitoring system to track the impact of AIDS on children, reduce the impact of AIDS on children and women, reduce stigma and discrimination and promote compassion, continue providing support for capacity building in paediatric AIDS, and develop a national framework on care and support for children living with HIV.



Philippines

Dr. Jose Gerard Belimac

Program Manager

National AIDS/STI Prevention and Control Program

Department of Health

Dr. Belimac began his presentation with an overview of the HIV situation in the Philippines, followed by responses and lessons learned as well as challenges remaining.

From 1984 to 2007 (December), there were 3,061 HIV cases reported to the Department of Health, three fourths (2,279) of which were asymptomatic and the remaining one fourth (782) were AIDS cases. Among the AIDS cases, 40 per cent (307) were already dead at the time of reporting. Unprotected sexual intercourse is still the leading mode of transmission (88 per cent). All other known modes of transmission, however, have already been reported in the country, including perinatal transmission, injecting drug use, blood transfusion and needle prick injuries. About 1.5 per cent of the total HIV & AIDS cases are younger than 10 years old and 12.9 per cent belong to the 15-24 age range.

As of 2007, the Philippines had an estimated 7,490 people aged 15-49 living with HIV, giving an overall national prevalence of 0.02 per cent among adults. Almost half of these estimates are Overseas Filipino Workers (OFW) and their partners, being followed closely by men having sex with men (MSM) at 34 per cent.

Sexually transmitted infections (STIs) in both vulnerable groups and the general population remain high. Prevalence of any form of STI among MSM in selected cities is about one third (32 per cent). Gonorrhoea remains the leading STI among male clients attending the Social Hygiene Clinics in 2006 (12.02 per cent). Non-Gonococcal Infection (NGI) is the highest among registered female sex workers at 7.7 per cent. Ulcerative STIs remain low at less than 1 per cent. It is important to note that majority of these STI cases are among people 19-24 years of age.

A 2005 special baseline on 'knowledge, attitude and practice' (KAP) done among youth (12-20 years old) in selected UNICEF project sites revealed moderate (30.4 per cent) to high (43.1 per cent) knowledge of HIV and condoms that proportionally increases with age, although a sizeable proportion still believes in the myths of HIV transmission. Sixteen per cent of the youths surveyed are sexually active. Condom use is still very low.

There is an emerging problem of injecting drug users (IDUs), a high percentage of which reportedly shares unclean injecting equipment. Among the IDUs, 29 per cent reported that they last injected with a previously used needle or syringe.

Cognisant of the importance of HIV and AIDS, the Government of the Philippines demonstrated its commitment to the prevention of the spread of HIV. It has complied with the 'Three Ones' Principle. That is, the Philippine National AIDS Council (PNAC), established in 1992, maintains its position as the **national coordinating body** for a harmonized and well-coordinated approach to HIV prevention, guided by **One Strategic Framework** – the AIDS Medium Term Plan IV (2005-2010). Evidence-based actions in the country will be further guided by the recently developed and implemented **One National M & E System**. Department circulars in different government agencies and PNAC were composed by 20 government agencies and six civil society organizations, including some comprised of people living with HIV and AIDS. To further localize the multi-sectoral responses, there is continuing advocacy to local government units to create and institutionalize Local AIDS Councils (LAC). Some local government units have, in fact, further localized these responses and created the Local AIDS Councils at the barangay level – the smallest political unit in the country.

An assessment of local policies aimed to generate awareness of HIV/AIDS programmes at the local level through a policy review conducted by UNICEF in 2005 to guide local responses, especially for vulnerable children and youth. The assessment highlights the need to increase policy awareness, implementation and integration of HIV & AIDS into existing children and youth programmes.

The Philippine Government has sustained its commitment to greater involvement of people living with AIDS (GIPA). In 2006, an organization of women formed BABAE PLUS, to ensure that issues and concerns of women and children with HIV are adequately addressed.

For prevention, HIV and AIDS awareness raising and education have been integrated into the curriculum of primary and secondary schools by the Department of Education. In 2007, the Commission on Higher Education, with support from UNESCO and UNAIDS, initiated the integration of HIV and AIDS into the curriculum of the bachelor degree course on education in order to prepare future teachers and educators. Continued prevention intervention by the social welfare sector was also done. IEC on HIV and AIDS are integrated into existing community-based programmes. Community-based social workers and GO or NGO child-focused institutions are further capacitated.

UNICEF supported the Department of Health in developing a module for voluntary confidential counselling and testing (VCCT) training, which provides opportunities to scale up standard, harmonized VCCT training in the country with further support from GFATM.

On PMTCT and paediatric AIDS, the Pre-Pregnancy Package is being pilot tested in selected sites, incorporating the provision of HIV & AIDS counselling and VCCT referral to men and women attending pre-marital counselling. PMTCT is still in its pilot stage in the country.

The development of a guideline on “Integrated Management of Paediatric HIV Infection and AIDS” and the initiation of its implementation in three major hospitals in collaboration with an NGO were new initiatives in paediatric care and treatment. The project provides a model of care for infected and affected children, including access to ARVs and psychological and social support through a network of partners.

To expand the access to treatment, care and support, the Government has expanded its Treatment Hubs to 11 DoH hospitals geographically-distributed across the entire country. GFATM and the DoH provided for the procurement of ARVs/OIs drugs including paediatric formulations. The social welfare sector initiated livelihood training, micro-assistance and/or referral for employment and provision/referral for scholarship/educational assistance for qualified children of PLHIV.

The monitoring system which provides data on counselling, blood safety, and adult and paediatric HIV clinical status was strengthened. The improved data system enhances the development of programmes, policies and standards for specific groups.

In 2007, the Philippine National AIDS Council (PNAC) developed and costed the operational plan of the 4th AMTP for 2007-2008. The government has continuously leveraged additional resources for the country's HIV and AIDS response. To further sustain treatment of PLHIV, the Philippine National Health Insurance Program has board-approved the benefit package for HIV. Finalization of the implementing guidelines is still ongoing.

On lessons learned and challenges, instilling good governance at the local level by building capacities of local chief executives and local partners plays an important role in the successful implementation of the HIV response. As commitments may change with the fluid political leadership, continued advocacy and technical support to LGUs are crucial.

The NGOs in the Philippines have good experiences in dealing with at-risk populations such as registered sex workers and men having sex with men. Very few, however, have experience in dealing with the most at-risk and vulnerable children and young people in a child-friendly and youth-friendly manner, especially to address HIV and STI prevention and protection issues. Therefore, building the capacity of existing NGOs and other service providers and strengthening partnerships between partners working on HIV and AIDS

and child protection sectors could increase coverage among most-at-risk and vulnerable adolescents and young people. This could lead to access to comprehensive services that address both STI, HIV and protection issues.

The Philippines will continue its prevention effort in the country guided by one national strategy through meaningful multi-sectoral partnerships and cooperation. To sustain the low-level prevalence in the country, prevention activities shall be expanded and accelerated.



Thailand
Dr. Siripon Kanshana
 Deputy Permanent Secretary
 Ministry of Public Health

Dr. Kanshana gave an overview of the HIV/AIDS epidemic in Thailand. Quoting from UNAIDS 2006 data, she reported that Thailand has 540,822 adults and 16,000 children estimated to be living with HIV/AIDS, 6,030 infants born to HIV-positive mothers and 241-423 new HIV-infected children. HIV prevalence among pregnant women is estimated at 0.87 per cent.

As of April 2006, Thailand has a National Policy on PMTCT, which contains the following provisions: voluntary HIV testing and counselling for all pregnant women; specific ART dosages for HIV-positive pregnant women during gestation, labour and after delivery (postpartum care); infant formula for 12 months to replace breastfeeding; HIV testing for infants at 12 months and, if positive, a re-test at 18 months; and appropriate care for mothers and children.

There have been increases from 2003 to 2007 in the number of women who gave birth (from 668,974 to 794,406), of pregnant women who were tested (from 97.6% to 99.7%), of HIV-positive pregnant women receiving ARVs (from 79.6% to 93.8%), of children receiving ARVs (from 97.9% to 99.5%), and of children receiving formula feeding (from 86.1% to 93.5%). Notable progress has been in the decreasing number of HIV-positive pregnant women (from 6,940 to 6,263).

In 2003, Thailand introduced the "CARE" programme for HIV-infected mothers and families, which aims to decrease the number of orphaned children and to promote the health and well-being of children under-five who are born to HIV-positive mothers. CARE is family-centred and provides comprehensive HIV-related services for HIV-infected women and their families (partners and children). Its services include clinical and immunologic monitoring, TB prophylaxis and treatment, prophylaxis for opportunistic infections, antiretroviral therapy where indicated, psychological and social support services, family planning services and HIV-prevention services.

Dr. Kanshana proceeded to discuss the ARV regimens for HIV-positive adults:

- Regimen 1 - D4T+3TC+NVP;
- Regimen 2 - D4T+3TC+EFV; and
- Regimen 3 - D4T+3TC+(IDV+RTV).

On the other hand, ARV regimens for HIV-positive children are as follows:

- Regimen 1 - AZT+3TC+NVP or d4T+3TC+NVP;
- Regimen 2 - AZT+3TC+EFV or d4T+3TC+EFV.
- In case of severe side-effects from NVP and EVF, these may be changed to dual therapy: 1 - AZT+3TC, and 2 - d4T+3TC.

Treatment and care guidelines for HIV-infected children in Thailand include proper diagnosis of HIV infection, ARV treatment, management of ARV complications, OI prophylaxis and treatment and psycho-social support. Thailand's National AIDS Program (NAP) has a benefits package that includes access to ARV drugs, lab monitoring, counselling, and HIV prevention.

Discrimination against PLHIV remains a major challenge. As revealed in a survey, 5 per cent would not care for a family member with HIV/AIDS, 37 per cent would keep it a secret if a family member was infected with HIV, 29 per cent thinks that a HIV-infected teacher should not be allowed to work, and 65 per cent would not buy food from an HIV-infected person.

Dr. Kanshana proposed some actions to ensure effective responses to HIV & AIDS:

- For the leadership to recognize the devastating scale of the epidemic and commit to tackling it; to involve all sectors of society in addressing the underlying socio-economic and behavioural roots of HIV transmission;
- To pursue continuously research and development, surveillance, monitoring and evaluation of data to be used in developing policies and programmes aimed at changing conditions;
- To undertake early and pragmatic action, knowledge and information management in the areas of provider support and customer protection and
- To promote a holistic approach to address human, social, economic and cultural aspects of the epidemic.

Discussions

On ensuring comparability of data across countries considering variations in definitions and usage of terminologies: Countries need to come up with standard definitions of terms, such as the definitions of age and vulnerability of children, among others.

On estimating service coverage using common indicators/measurements: Measurement may be done at two levels: population and service use. Population indicators measure the extent of the disease burden as a whole. We need to have data on services to determine the progress of response. Service-based indicators may be obtained yearly. Population-based indicators need not be every year. There should be different ways of getting population-based data. On service coverage, measurement could be based on the number of service recipients.

Session 2.

Protection and care: Global and regional approaches



**Enhanced Protection for Children Affected by AIDS:
A companion paper to the Global OVC Framework**
Aaron Greenberg, Child Protection Specialist, UNICEF New York

Mr. Greenberg discussed the “Enhanced Protection for Children Affected by AIDS” within a broader global context, explaining the unifying principles of the paper and outlining its key recommendations.

The Global Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS was developed in 2004. It emerged from the Global Partners Forum on Children and AIDS, was developed via a broad consultation and later endorsed by a large number of governments, NGOs and civil society groups.

The Global OVC Framework is in line with the Universal Agreement on programming strategy that aims to strengthen the capacity of families to protect and care for orphans and vulnerable children; mobilize and support community-based responses; ensure access for orphans and vulnerable children to essential services; ensure that governments protect the most vulnerable children; and raise awareness at all levels through advocacy and social mobilization. While the Framework emphasizes strategy, however, it does not go into specific detail on tactics. Thus, there was the need for a Companion Paper that ‘spells the how.’

Vulnerable children are more likely than their counterparts to experience a protection violation, including being trafficked, married off at an early age, or engaged in the worst forms of child labour (including prostitution). These violations, in turn, increase the children’s risk of infection. Children are also

made vulnerable by income poverty at the household level, lack of access to basic services, loss of parental care and stigma. Children affected by HIV and AIDS often experience multiple, overlapping and clustering vulnerabilities that are shared by other children, such as the extremely poor, children living with a disability, migrant children, children who lose one or both parents to any cause, etc.

Mr. Greenberg proceeded to discuss the basic principles of targeting:

- Targeting should be broad, perhaps organized by geography or the type of poverty.
- Access to services should be increased for all those that are most vulnerable and marginalized in the target area.
- Care must be exercised when using AIDS-criteria or any other specific yet hard-to-define subset of vulnerability as a pre-determined targeting mechanism.
- In general, the targets should be the poorest, the most excluded and marginalized, and those that lack access to basic services.

By targeting in this way, programmes and systems will capture those children and families that are being affected by AIDS without using AIDS as a criterion for eligibility. Mr. Greenberg pointed to three action areas, namely: social protection; legal protection and justice; and alternative care.

Social protection can refer to: the implementation of social transfer programmes, as there is

strong evidence from Cambodia that HIV-affected households face high expenditures; investments in family support services such as early childhood day care, parenting programmes, and social work, since income poverty can be addressed by relieving child-care responsibilities and freeing up time for adults to work; and community involvement in the design and planning of social transfers and family support services.

The action area of legal protection and justice includes these tasks: combating disinheritance by investing in legal support for the poorest and most marginalized; improving civil registration systems, primarily birth registration; strengthening and/or developing specialized child protective services in police, justice and social welfare systems; strengthening, developing and implementing legislation and enforcing policies on child labour, trafficking, sexual abuse and exploitation as embodied in the new National Plan of Action on Commercial Sexual Exploitation of Children in Lao PDR; and supporting community-based monitoring mechanisms.

For alternative care, the needs include: finding appropriate ways of supporting and monitoring informal care arrangements, since strong evidence suggests that extended families (like grandparents) are caring for orphans and vulnerable children; improving the formal care system by investing in foster care, ensuring that children are not placed in institutional care unless absolutely necessary and supporting family reunification; and developing government and community-based protection and monitoring mechanisms.

Studies across the region indicate that stigma related to HIV and AIDS is high and may be one of the primary barriers affecting children's access to services. This is even true for HIV-negative children living with an HIV-positive caregiver. Two crosscutting recommendations seek both to address stigma and to strengthen the state's social welfare sector. First, addressing stigma requires: the facilitation of open discussions to promote awareness at all levels,

like the nation-wide campaigns in Thailand that have seen significant positive returns; the sensitization of the media to issues of HIV and AIDS and protection risks; and the training of national and community leaders to stimulate discussion. Second, to strengthen the state's social welfare sector, it is necessary to increase budgetary allocations to government agencies responsible for social welfare, implement alternative care and protective services, invest in human resources within the social welfare system, and develop regulations, guidelines and coordination mechanisms.

State responses should build on good practices. Some examples include:

- Ministerial-level collaboration in Viet Nam: The draft of the National Child Protection Strategy 2008-2020 provides a comprehensive national framework.
- Ministerial restructuring in the Pacific Islands: In Vanuatu, the new 'Ministry of Justice and Social Welfare' was formed to take the lead in the design of the new Child Protection Programme. Elsewhere, in the Solomon Islands, the new Ministry of Women, Youth and Children's Affairs was established, and in Kiribati, a child protection unit was instituted and resourced within the Ministry of Internal and Social Affairs.
- Child Protection Monitoring System in Thailand: A model system in six Southern provinces is currently being implemented. Already, local actors are using information from that system to develop community plans for child protection, thereby paving the way for budget allocation and service delivery.
- Social Work in Cambodia: Capacity building has been happening at provincial and district levels.

Mr. Greenberg ended by saying that the Companion paper can be used as a planning and budgeting tool by countries, as well as a partnership mobilization tool that could draw people together around a common agenda.



Evidence base: Programming for children affected by AIDS in low prevalence and concentrated epidemic countries

Dr. Barton Burkhalter, Director of Operations Research and Associate Director, Quality Assurance Project, University Research Co., Bethesda, Maryland, USA

Dr. Burkhalter's presentation focused on evidence useful for OVC programming. He was part of a joint study that gathered evidence to support programming for children affected by HIV and AIDS in low prevalence countries. Researchers conducted a literature search of 414 relevant documents from 14,343 "hits" and 77 documents on Asian countries, as well as 65 literature reviews. The investigations sought to find out the situation (context) and the intervention (what works). Evidences were categorized into strong (controlled recurrent results), moderate (consistent recurrent results) and gaps (little or no evidence). Programming strategies with strong or moderate evidence totaled 44 for good situational approaches and 15 for good intervention approaches.

Challenges existed in the topical areas of health, nutrition, socio-economic, education, psychosocial, protection (legal), placement, and stigma and discrimination. Areas not addressed per se are ARV and its future impact, targeting and going to and operating at scale.

For health, there is strong situational evidence of healthy HIV-mothers reducing the risk of child death. The morbidity of uninfected children is the same in HIV and non-HIV households (moderate situation evidence) in the cases of India, Cambodia and Malawi. Children in HIV households make fewer health visits in some countries (moderate situation evidence but no good intervention evidence, strong or moderate).

For nutrition, strong situation evidence is found to suggest that HIV and AIDS and malnutrition are mutually reinforcing and that infant-feeding methods used by HIV mothers significantly affect an infant's HIV status, morbidity and mortality. Strong intervention

evidence is found for safe breastfeeding and that a single-dose of ARV can reduce MTCT. On the other hand, there is moderate intervention evidence that improved counselling and education about infant-feeding decrease HIV transmission and increase HIV-free survivors and that community education and supplementary feeding sometimes improve nutritional status.

For the topical area of socio-economics, there is strong situation evidence that: 1) Less income is related to lower productivity for households with HIV adults; 2) HIV-affected households have higher expenditures; and 3) There are inadequate support services for HIV-affected households. On the other hand, there is moderate situation evidence to suggest that HIV-affected and female-headed households are not only worse off than non-affected households but also have more concerns in terms of meeting basic needs. Moderate intervention evidence indicates that cash transfer programmes may help HIV-affected households more than non-affected ones.

Dr. Burkhalter shared a study done by Wyss and Company on Chad in 2004. The study matched a case-control comparison of costs in 193 HIV and 193 non-HIV households, where a "case" was a HIV-positive adult selected from HIV group or facility HIV programme in four areas, and a "control" was an adult in a nearby non-HIV household of the same age, sex, and position (e.g., student, traders, etc) as the "case." AIDS "costs" included household and health expenses, lost income, and funeral costs.

Costs estimated by interview are shown as follows:

Health expenses: Of all monthly household expenses, the cost of health care is the only area of significant difference between HIV and non-HIV households. If HIV households aver-

age \$82.80 while non-HIV average only \$4.30 in non-HIV, the difference is \$78.50.

Lost income: In an HIV household, both the ill patient plus in-home caregiver lose work days, totalling 24.1 days/month for HIV cases, while only an average total of 2.5 days/month were lost for controls, a difference of 21.6 days/month. This difference translates to \$38.50 lost/month, assuming 30 workdays and \$53 income per month (if the earners are healthy).

Total costs: Assuming 6 months of costs before death plus funeral costs of \$133, the total additional monthly costs of one AIDS patient was estimated to be:

$$6 \times (\$78.50 + \$38.50) + \$133.00 = \$836.$$

These estimates do include questionable assumptions, such as the figure of 30 workdays per month or an average monthly income of \$53 (\$636/year).

For the next topical area of education, it was found that the effect of orphan-hood on school enrolment is mixed and unclear, but the biological closeness of the caretaker and household structure have an effect (moderate situation evidence). In HIV-affected households, school enrolment of young children is not affected, but enrolment does decrease with older children (strong situation evidence). Furthermore, HIV-affected children and families fear HIV-related discrimination from peers, schools, etc. (moderate situation evidence). HIV-affected children drop out of school for various economic reasons, not just because of school fees (moderate situation evidence). Still, education does help protect against acquiring HIV, a phenomenon known as the “education vaccine” (moderate intervention evidence). Lastly, financial subsidies sometimes increase enrolment (moderate intervention evidence).

For psychosocial challenges, findings reveal that: 1) HIV-affected children are more vulnerable to psychosocial problems than unaffected children (strong situation evidence); 2) Familial and parental functioning is the most important predictor of the psychosocial wellbeing of HIV-

affected children (strong situation evidence); 3) HIV-affected children face different psychosocial problems at different ages (moderate situation evidence); and 4) Psychosocial services help mitigate negative impacts upon HIV-affected children (moderate intervention evidence). Notably, neither caregivers nor health workers identified psychosocial needs of HIV-affected children as important but saw material and financial issues as more important (Thailand, Safman 2004).

For the issue of protection (legal), it was found that: 1) Many governments provide little protection to vulnerable children, including the HIV-affected (strong situation evidence); 2) Laws rarely mention orphans and other HIV-affected children in low prevalence countries (moderate situation evidence); 3) Legal systems often don't protect HIV-affected children in terms of financial, care, service and placement needs; 4) Enforcement is worse (moderate situation evidence); and 5) Enforcement facilitation has helped mitigate legal problems for HIV-affected families (moderate intervention evidence).

In terms of placement issues, there is strong situation evidence to indicate that: 1) Most HIV-affected children live with HIV-positive parents; 2) Most AIDS-orphans are fostered informally to extended family, with grandparents often as the caretakers; and 3) Informal fostering can lead to welfare loss. On the other hand, moderate situation evidence has suggested that: 1) Adoption and other formal placement options are less frequent and often mired in legal problems; and 2) HIV-infected children face more placement barriers than other children. Four studies found that institutional care should be the last resort (strong intervention evidence).

Dr. Burkhalter cited the review paper done by Frank et al. in 1996. A scientific literature review, the paper analyses the impact of orphanages and institutionalized care on children 0-5 years. Some salient findings are as follows:

- Infectious disease: **Overwhelming scientific evidence** demonstrates that diarrhea and

respiratory infections are far more frequent and intense in resident institutions than in small dwellings.

- Cognitive and language skills: **Strong scientific evidence** suggests that permanent development is delayed unless there are very low ratios of adults-to-children and a high degree of interaction.
- Nutrition: **Inconclusive scientific evidence** exists on the feeding and nutrition of institutionalized children.
- Socio-Emotional: **Limited scientific evidence** indicates that institutional care of young children can result in long-term adult problems with intimate relationships and productivity.
- Child abuse: Although physical and sexual abuse is rare in high quality and well-funded institutions, it is all too frequent (and covered up) in lower quality institutions.

For stigma and discrimination, the literature review reveals that: 1) The stigma of HIV and AIDS attached to children is prevalent (strong situation evidence); 2) Communities and schools discriminate against HIV-affected children (moderate situation evidence); 3) HIV-affected children expect stigma (moderate situation evidence); and 4) Stigma aimed at parents or guardians can affect children as shown by studies in India, Cambodia, China

and multi-country studies (moderate situation evidence). There is moderate intervention evidence that stigma can be reduced by the use of ART, increased visibility and participation of HIV-infected persons, and anti-stigma information in schools.

Dr. Burkhalter further shared results of some studies done in India, Cambodia, China and Indonesia/India/Philippines/Thailand, as follows:

- **India:** Of the 6,224 non-HIV adults interviewed, 44 per cent of men and 56 per cent of women would not let their children play with children from HIV-infected households, and of the 2,385 HIV-positive adults interviewed, 3 per cent said their children could not play with other children (Pradhan 2006).
- **Cambodia:** Of 500 parents in HIV households, 44 per cent said their non-HIV children were discriminated against due to HIV in their household (Alkenbrack 2004).
- **Indonesia/India/Philippines /Thailand:** Of 764 HIV adults, 2.4 per cent said their children were removed due to their HIV status (Paxton 2006).
- **China:** A qualitative study reported that bullying, discrimination and stigma against non-HIV children from families with HIV existed (SCF/UK 2005).



Children and AIDS: Rethinking strategies for protection and care opportunities and challenges for the East Asia and the Pacific region
Jerker Edstrom, Research Fellow, Institute of Development Studies/
 Consultant UNICEF East Asia and Pacific Regional Office

Mr. Edstrom's presentation raised and discussed four main questions:

- Who should we be talking about? Which children?
- What are the characteristics of the epidemic in the region?
- How are strategies in EAP addressing Protection and Care of children in relation to HIV?
- Where next for children and HIV and AIDS in the region?

Who should we be talking about? Which children?

First, there is a need to define 'vulnerability' in terms of children and their relationship to HIV and AIDS. 'Vulnerability' is a common term used in public health and social and economic development policy, yet it is differently constructed in different sectors. In relation to HIV, children (and adults) may be considered vulnerable to HIV because of HIV infection and/or because of the impact of HIV and AIDS

(including from a parent’s illness and/or death caused by HIV). We can relate children’s HIV-related vulnerability to broad categories in HIV and AIDS programming such as prevention, care and treatment, and impact mitigation.

Mr. Edstrom proceeded to discuss the changing focus over time regarding children and AIDS. According to him, the 2004 Framework advised against targeting children on the basis of HIV and instead advised that communities define and respond to child vulnerability.

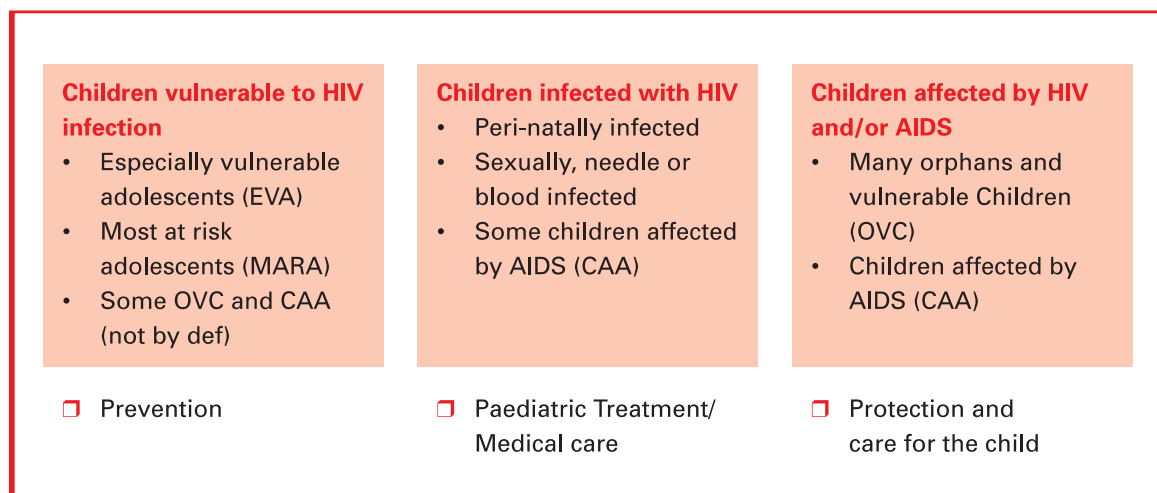
There are three categories of ‘orphans and other vulnerable children’: 1) orphans (single and double) from any cause; 2) children having suffered from a caregiver’s serious illness or death; and 3) children outside family care (UNICEF/UNAIDS, 2004).

The “Call to Action” (2006) gives attention to specific challenges for children with HIV, calling on governments to protect children and for prevention to be relevant, a concept which needs further elaboration.

The concept of ‘children affected by HIV and AIDS’ (CAA) was subsequently used for children in relation to HIV and AIDS – the same children as OVC, HIV positive children, and children made vulnerable by HIV and AIDS (which is less defined). Neither OVC nor CAA clearly defines children in relation to vulnerability to infection. As most OVC and CAA are above 11 and – at least potentially – vulnerable to infection, this remains a gap.

Some terms, like ‘especially vulnerable adolescents’ (EVA), and ‘most at risk adolescents’ (MARA), were developed for older children. MARA includes those adolescents most at risk of HIV infections, such as injecting drug users or those who have sex with others who are likely to be HIV positive. On the other hand, EVA includes those adolescents who are vulnerable to infection from living on the street, being out of school, and working. Though the groups overlap, there is insufficient information about how much overlap exists and about how children in one category may move into others during adolescence. Thus, it is crucial to be clear about which children need to be targeted for what policies and services.

Figure 1



In addition to those affected by the impacts of HIV and AIDS, policies for protection and care of children should help infected children and the many others vulnerable to infection.

What are the characteristics of the epidemic in the region?

In 2006, five million people in Asia were living with HIV, while just over two million of those were estimated in 2005 to be in East Asia and the Pacific. HIV prevalence in Asia was highest in South-East Asia. Prevalence has been generally low (below 1%), with injecting drug use, sex work and sex between men as the

main drivers. Children are likely to be affected from sex workers and drug users in early stages, then less so after clients and partners get infected.

Epidemic trends vary between countries, including:

- Mature epidemics in Myanmar, Thailand and Cambodia, with some sustained declines in prevalence;
- Young epidemics in Indonesia and Viet Nam;
- Diverse epidemics in China; and
- An expanding epidemic in Papua New Guinea, driven mainly by heterosexual transmission in rural areas.

What is the context of child health and orphans?

In terms of child health, generally, East Asia and the Pacific compares favourably to most regions. UNICEF (2005) reported an estimated 132.7 million orphans (0-17 years) worldwide, and of these, 15.2 million was estimated to have lost one or both parents to AIDS (11% of all orphans). There is no reliable estimate, however, for children orphaned by HIV in the region, although the number of orphans from all causes was estimated to be around 35 million.

How are strategies in EAP addressing Protection and Care of children in relation to HIV?

On child protection and alternative care: Legal frameworks for protection are weak in most countries. There is insufficient evidence of strategy evaluations to address the protection of children affected by HIV or AIDS. International evidence on the drawbacks for children of institutional care is very strong. There are major gaps, however, in understanding and knowledge of community-based interventions or of what leads to better placement solutions, etc. Also, protection and services for street children are poorly developed. This means that there should be a high priority for development, given the high vulnerability of street children to HIV infection from loss of family care.

On social protection and child poverty reduction: Social welfare programs, such as cash transfers to poor families, appear to help children. However, information regarding specific impacts upon children affected by HIV in EAP is limited. Formal programmes in China and Viet Nam are aimed at OVC amongst others but involve very low levels of payments. Contributory social insurance schemes, e.g. in Thailand, have failed the poorest. In Myanmar, communities, individuals and religious institutions provide support to orphans and vulnerable children. There is a lack of information, however, about children and their needs and about existing support activities. In Cambodia, food aid is provided to some families with HIV by home-based care teams and by NGOs in collaboration with local health staff. In Indonesia and the Pacific, strategies for meeting economic needs of children affected by HIV remain underdeveloped.

Where next for Children and AIDS in the region?

Mr. Edstrom suggested the following actions:

Potential for a transformative social protection framework on protection and care of CAA

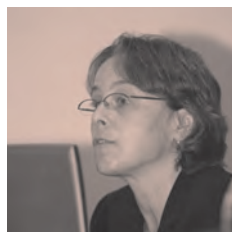
Social protection concerns poverty-focused, predictable and equitable social transfers for the poor and marginalized. A “transformative social protection” framework should be beyond welfare payments to the poor, including protective transfers of food or cash; preventive insurance against health costs; promoting access to credit for productive livelihoods; and transformative strategies addressing structural or legal obstacles to empowerment, e.g. discrimination. In terms of the framework’s potential, social assistance can be linked to other approaches, such as re-distribution, access, rights and claims. Effective solutions need to address the characteristics of the epidemic. For instance, social protection should be linked to child protection, education, prevention and health.

'Obvious' target groups, such as double orphans, are poor proxies for children affected by and vulnerable to HIV. Furthermore, the need to recognize and reach poor children of sex workers, children of drug users, MARA and EVA must be met. Finally, targeting might address questions of what services and programmes for whom and for which vulnerabilities. Overall, target groups need to overlap, creating linkages and referral chains.

Setting strategic priorities in relation to epidemic

In terms of concentrated epidemics in EAP, strategies depend on the nature and phase of epidemics, always asking how children figure

into this. For example, the children of parents with high-risk behaviours might have multiple HIV related vulnerabilities and thereby have a range of support and protection needs. Also, stigma, discrimination and the social exclusion of marginalized children and adults entail complex vulnerabilities beyond poverty, which could be addressed with linked responses. The costs for these specific protective transfers, preventive or promotive strategies need elaboration within larger poverty alleviation measures for all children and other health and social priorities. Furthermore, solutions need to devolve to local community settings, and marginalized key groups need to engage in developing solutions.



The Continuum of Care: Enhancing access to HIV prevention, care and protection for children, youth and families in Asia and the Pacific
Dr. Celine Daly, Director, Technical Unit Asia Pacific Regional Office, Family Health International

Dr. Daly's presentation revolved around the following:

- What are the needs in Asia and the Pacific?
- Are we doing enough to reach children, youth and families?
- What are promising models to address needs?
- Where to next?

The following issues relate to children and HIV:

- In concentrated/low prevalence epidemics, populations vulnerable to and living with HIV are highly stigmatized and behaviours criminalized.
- Children and youth tend to be highly vulnerable, particularly children of drug users, sex workers, MSM, migrants and prisoners.
- Stigma creates major barriers for children and families in terms of accessing social welfare and health services.
- Youth vulnerable to HIV slip through the cracks.
- In most countries, very limited data is available on the numbers and specific

needs of children, youth and families vulnerable to, living with and affected by HIV.

How well are we reaching children, youth and families in need of HIV services?

Dr. Daly said that there are interventions that work to stem HIV transmission and extend care and treatment for PLHIV, despite limited access to these essential services. While there were improvements in access to key services from 2003 to 2006, growth is slow and in some areas (such as in PMTCT and among IDU) shockingly so. In order to mitigate the impact of HIV on children, youth and families, we need to ensure that prevention services are targeted and reaching scale. For example, for IDU, major contributions to expanding epidemic coverage of needles and syringes need to be at least 80 per cent. The Universal Access Goal for ART is 80 per cent by 2010, and there is a long way to go. There is significant unmet need for ART in the region for both adults and children.

So what seems to be working? Continuum of Care (CoC) is an HIV service delivery

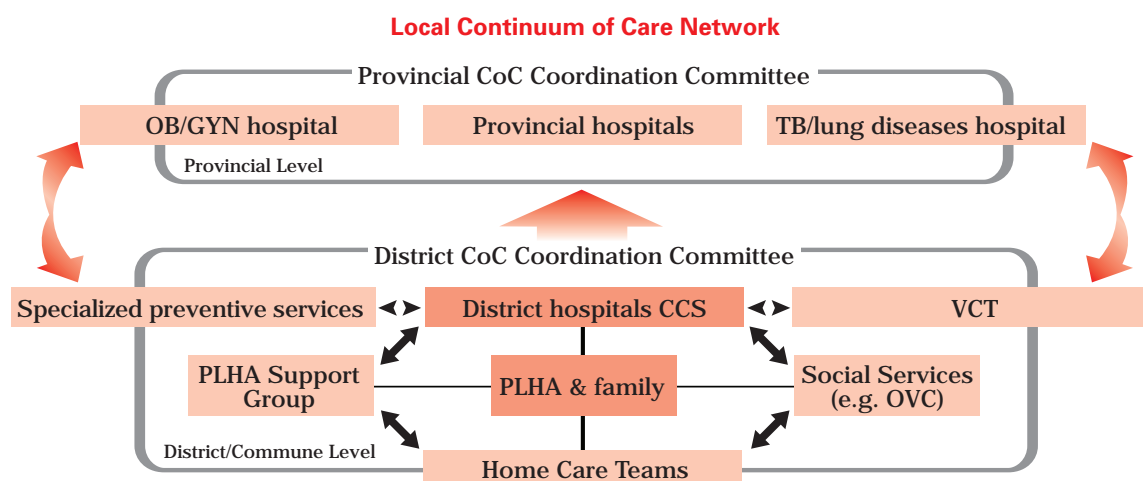
system based on a coordinated network of complementary prevention, treatment, care and protection services provided by different organizations (governments, NGOs, PLHIV groups, etc) which together add up to a **comprehensive service package** for adults, children, youth and families vulnerable to, living with and affected by HIV. Through this package, they are able to access the different services they need throughout their lives.

The key principles of CoC are coordination and partnership, multi-sectoral involvement (including the health, social welfare, education, etc., MARP/PLHIV/child/family sectors), and targeted intervention established only where there is a need. CoC organizes, coordinates

and extends services to those vulnerable and living with and affected by HIV.

Thailand initiated the CoC approach in the early 1990s, and then Cambodia adapted it in 2003 and took it nationwide. In other countries, such as Viet Nam, this approach is in the process of being expanded. In Papua New Guinea, it is just getting started. Other countries implementing CoC are China, Indonesia and Nepal. The approach initially focused on better coordinating HIV care services from home and community to the health care facility. This approach has since been expanded to incorporate prevention and OVC care and protection.

Figure 2



So what does a local CoC look like?

The CoC is initiated through a local assessment with the district hospital and PLHIV, which looks at what services already exist, what are missing and if there are pre-existing linkages between key services (e.g. CT and TB). Then a CoC Coordination Committee is established (or, an existing committee is enhanced) which includes the key individuals who need to be sensitized and helps with improving access to services for MARPs, PLHIV and OVC. In Viet Nam, for example, the CoC Coordination committee linked all vital services together, including the district hospital, district office of social welfare, people's committee, PLHIV groups, women's

union, Red Cross and NGOs/CBOs. This committee then helps to create a referral system, including linked or unified referral registers and forms, a service directory, a client-held record book and the use of routine meetings to solve problems. It also ensures that PLHIV take part in service delivery, such as working as counsellors, lay health care workers in outpatient clinics (OPCs) and key team members in community home-based care (CHBC) and PLHIV support groups to get from one service to another when needed. The OPC, CHBC and PLHIV support groups are hubs of service delivery for PLHIV and families. The specialized prevention services are hubs (e.g. drop-in-centres and clubs) for MARPs.

The local CoC includes a combination of targeted primary prevention services for all including youth. Ensuring access to counselling and testing for MARPs is essential.

PMTCT issues: While more pregnant women are being tested for HIV, only very few are receiving ARVs. Barriers include stigma issues (fear of disclosure at hospital, so they do not return) and the fact that few women deliver at the hospital (e.g. Cambodia, PNG). Ideally, HIV-positive women would be clinically assessed at the HIV clinic and have their CD4 count checked. It would then be determined if they are eligible for ART, or if not, then they would be placed on AZT at 28 weeks (or as soon as possible thereafter).

EID issues: 1) 33 per cent of children with HIV die before age one and 50 per cent before age two; 2) Very high LTFU is in existing PMTCT programs; 3) There is low active case detection through existing PLHIV households; 4) Even when children are tested, lab diagnostic capacity (no PCR, and if there is PCR, no DBS in place) is often limited to anti-body testing, which means that children can only be diagnosed from 12-18 months. It is recommended that infants be first tested at 6 weeks.

What are the benefits and effects of CoC?

CoC helps to limit PMTCT and LTFU, encourages active case finding and provides a forum for advocacy for introducing PCR and DBS. Linkages to protection include diminishing barriers for vulnerable youth and OVC accessing government and NGO protection services. The CoC committee serves as an advocacy venue for protecting the needs of this population. CoC has been taken to scale with children on ART increasing in Cambodia (94%) and Thailand (>95%). A significantly higher ART coverage in maturing CoCs could be observed. Other benefits of CoC include the reduced cost of service delivery. Modelling of CoC shows cost savings such as more efficient use of resources, less duplication of services, fewer hospitalizations and a reduced lost to follow-up (Martin 2007; Terris-Prestholt et al 2007). Among 34 service delivery sites, the non-CoC approach resulted in 18 per cent LTFU, whereas the CoC approach had 3 per

cent (Etienne et al 2007). In terms of improved ART outcomes, a recent study in Malawi showed the mortality rate between those enrolled in a CoC program versus those who were not was 3.5 per cent to 15.5 per cent (Zachariah et al 2007).

What more needs to be done to address the needs of families, children and youth?

CoC for family, youth and children still has a long way to go. The following key gaps need to be addressed:

- Adequate scale in targeted services for most at risk youth, including the development of youth life skills, their negotiating capacity, confidence to put what youth know into practice and make informed choices about sex and drugs
- PMTCT coverage still far too limited and needs to be targeted
- Early infant diagnosis in order to make strategic investments in PCR/DBS
- Adherence and psychosocial support tailored to the specific and diverse needs of children and youth living with HIV
- Nutrition and access to schooling
- Appropriate psychosocial support, cognitive development and care (e.g. counselling, therapeutic play) for children/youth and orphans and vulnerable children
- Very limited protection services needing significant bolstering to ensure they are available and effective for all OVC

Apart from the need to achieve scale in service coverage, some key aspects of services have to be urgently developed, such as:

- Enhancing or expanding existing CoC programs and developing new CoC programs based on local need
- Ensuring that updated national guidance and SoPs are available on HIV prevention, CT, PMTCT, care (OI, palliative care, nutrition) and treatment of infants, children and youth, as well as care and protection of OVC
- According to need, integrating a CoC approach into the National Plan of Action on Children & HIV; furthering resources and expanding the prevention and youth-friendly

services where youth are at risk and/or living with HIV; targeting CT/PMTCT services towards the most at risk populations; creating family-centred care by integrating HIV paediatric care and adult services and establishing new sites as needed; and building capacity of existing social welfare and protection services for vulnerable children and families, thereby minimizing parallel structures

- Training and supporting work with infants, children, youth and families, which require many new skills
- Where CoC efforts already exist, further developing and integrating missing elements and ensuring that key guidance and SOPs are in place

Discussions

On evidence to show that stigma was addressed well, particularly in low prevalence, low resource countries and on the implications of targeting to reduce stigma:

Involving people living with HIV/AIDS helps to reduce stigma. With ART, children are more active and more participative; however, health care discriminates against HIV affected children. In Uganda and Thailand, national and multiple levels of dialogues have positively impacted reductions in stigma.

Targeting and stigma often go together. How do we target without stigmatizing? FHI is working with high-risk children, and children of HIV-positive households become targeted. At the same time, broadening them out, there are other vulnerable kids in the same community, and some programmes are for the whole community, not just the HIV affected. There is no clear response to the question, as this depends on the local situation.

Targeting creates stigma, and stigma makes targeting difficult. It is always us targeting them, calibrating our indicators. We always focus on the bad, poor, passive, and vulnerable, as if they can't do anything by themselves. People know their own situation more than service providers ever can. For instance, from the experiences (IDS) of working with sex workers and IDUs, frontier prevention projects are implemented to get them involved in community assessments, mapping out and designing solutions, which eventually lead to services being developed. It is not all about vulnerable groups, not just children in difficulties. Indeed, more needs to be done in terms of how to make children's participation and policy development more meaningful.

In terms of targeting, UNICEF NY counts on referrals to reach infected/affected children. There is a need, however, to ensure that across the social welfare sector, there is an understanding about these referrals.

From an FBO experience, donors have one definition of targeting which is time-bound and limited. On the other hand, FBOs have broader coverage.

It is difficult to define and target street children. A good categorization of street children for surveillance would be extremely useful. For instance, we can find street children engaging in transactional sex not called street children.

In Ukraine, a correlation between lack of parental supervision of children and lack of resources was found.

In terms of challenges to implement CoC interventions in PNG given the role of children and women in society, FHI in PNG has just started, and so they cannot say much. The Clinton Foundation found many groups in PNG, thus making it difficult to work on home-based and community-based care. The fact that there are more than 860 languages in PNG also poses a challenge in producing messages on HIV and AIDS.

In terms of the role of FBOs, in PNG, it was very obvious that FBOs are a key component, and they do not just look at client-based services. FBOs may be doing counselling and testing, but they should communicate more about their work.

FBOs are doing a lot of the necessary work at the community level, such as building a lot of orphanages, while other FBOs are doing incredibly good work and trying to find linkages with the State.

FBOs are going to be there on the frontlines long after donors leave, and they need to be at the table with government and cooperate. They should, however, not be given preferential treatment. FBOs need to look at evidence about both good and bad practices.

Session 3.

Country examples responding to children affected by HIV and AIDS



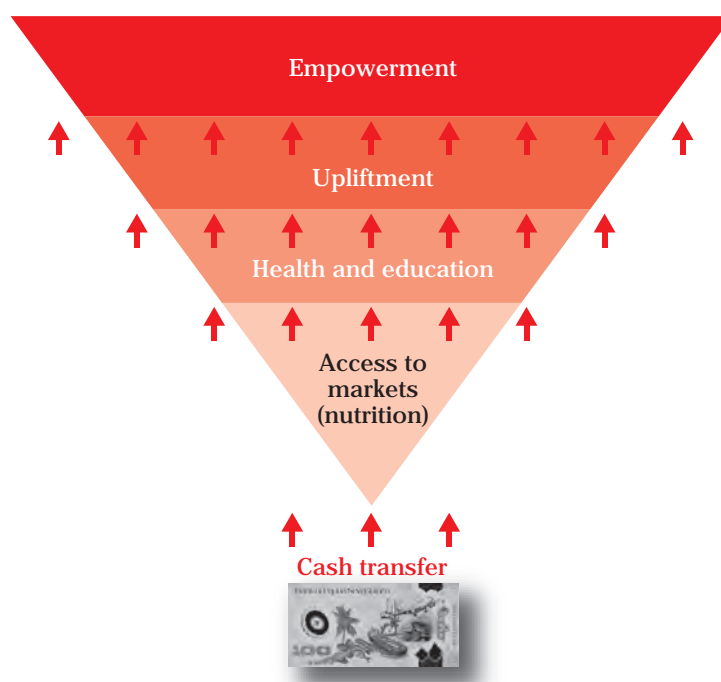
Consultation on the cash transfer programme in Papua New Guinea

Dr. Michael Samson, Director of Research, Economic Policy Research Institute, South Africa/Consultant of UNICEF East Asia and Pacific Regional Office

Dr. Samson discussed the impact levels of social cash transfers in Papua New Guinea: access to markets (nutrition); health and education; upliftment; and empowerment. He said that Papua New Guinea poses many challenges to HIV & AIDS policy since the country faces problems related to poverty, food security and, in particular, violence against women and children. Papua New Guinea has the highest prevalence of domestic violence in the world, with 75 per cent of children living in homes where violence is endemic. Furthermore, girls and women remain vulnerable to sexual exploitation. One evolving response to HIV & AIDS is the social cash transfer programme, part of a comprehensive national approach that seeks to empower female caregivers with children.

Social cash transfers are regular payments of money to poor and vulnerable individuals or households, usually by the government or another institution, to tackle risk, poverty and vulnerability. Cash transfers have a range of impacts. First, there is almost always an improvement in food security. Programmes examined in the Americas, Africa and Asia show other impacts in terms of human capital, such as providing poor children with access to education and health services. In time, livelihoods are improved through microfinance and enterprise. While social cash transfers are better used to manage social risk, they can result in employment creation.

Figure 3: Impact of cash transfers



The unique profile of poverty in Papua New Guinea makes cash transfers less relevant to poverty eradication than in other countries. There is relative food abundance, and it is well distributed. The 'wantok' social system, a complex exchange system, also provides an informal social safety net for the poor. Programmes can only be successful if they interact with the wantok system. Negative factors in this system, however, are the low status of women and the rates of domestic violence that are among the highest in the world.

The role of cash transfers, therefore, was not to tackle poverty but to empower women. The transfers targeted the areas of greatest vulnerability: HIV and AIDS, economic disempowerment and violence. To be effective, the cash transfer programme needed to be targeted geographically and be universal within the targeted areas. It is not a stand-alone intervention but part of a comprehensive approach to empower women. It must be integrated with the wantok system without reinforcing it or contradicting it.



Provincial policies for aid and protection of children affected by AIDS in Henan Province in China

Yang Guangwei, Deputy Division Director, Department of Social Welfare and Social Affairs, Ministry of Civil Affairs, China

Mr. Guangwei's presentation was divided into three main parts:

- National government guidance,
- Experiences from Henan province and
- Future work.

The Ministry of Civil Affairs (MCA) has most of the responsibility for developing and issuing policies on providing support for children affected by AIDS. The MCA established the professional qualifications system and allocated the amount of RMB 45 million to support the setting up of assistance and placement guidance centres. Jointly with the Ministry of Education, the MCA issued a policy to strengthen educational assistance, and with 14 other Ministries, it issued a policy on the provision of comprehensive assistance.

The programme has the following attributes:

- Geographically targeted to areas of high vulnerability of women and children, such as settlement areas for internal migrants, mining areas in Western Province and rural villages
- Universally provided to female caregivers with children in these targeted areas, including closed registration at the pilot stage and a role in the wantok system
- National priority for a comprehensive approach to empowering women – under the National Office for Women in the Ministry for Community Development, it is given high priority among many development partners, and key national stakeholders are integrally involved in the design phase.

Empowering women is the best way to protect children, as it reduces their vulnerability to HIV and AIDS and promotes development. Women with an independent income are more likely to educate themselves and their children. This is a long-term initiative that is transforming the lives of children. It is working because it is being applied in the country context by the people of Papua New Guinea to address the crucial priorities that they themselves have identified.

Mr. Guangwei described the situation of AIDS and children in Henan Province. Henan has a population of 98,690,000, of which 35,232 people are infected with AIDS and more than 40,000 children are affected by AIDS. Data on children include:

- 2,153 children infected by AIDS;
- 2,844 children orphaned by AIDS;
- 5,191 children in single-parent families caused by AIDS deaths; and
- 32,000 children with parent(s) infected with AIDS.

The Policy Framework of Henan focuses on three aid models, four placement ways, and three care and support methods.

Aid models include cash transfers for living assistance, educational support and medical aid. In terms of cash transfers, each child orphaned by AIDS receives 200 Yuan per month, a minor child in single-parent family caused by AIDS receives 65 Yuan, and a child who lives in a family infected with HIV and/or AIDS receives not less than 30 Yuan per month.

Educational support exists at three levels:

1. Compulsory education phase – provision of free textbooks, exemption from incidentals and subsidy for boarding expenses;
2. Senior and middle school – provision of special grants in the amount of 800 Yuan for each person per year; and
3. College and secondary schools – priority access to student loans (All students enrolled in secondary school are entitled to state grants).

Medical aid is provided as follows: free anti-virus and anti-opportunistic infection treatment for children infected with HIV; free basic medical insurance for children orphaned by AIDS; and enrolment in a new-style rural medical system and inclusion in urban and rural medical aid systems for other children affected by AIDS.

Four placement ways for children affected by HIV & AIDS include the adoption of about 0.1 per cent; family foster care of about 85 per cent; simulation family parenting of about 4 per cent; and agency foster care of about 11 per cent.

Three care and support methods refer to psychological rehabilitation, skills training, and community integration.



National Plan of Action for orphans, children affected by HIV and other vulnerable children in Cambodia

H.E. Keo Borentr, Director General of Technical Affairs, Ministry of Social Affairs, Veterans and Youth Rehabilitation, Cambodia

Mr. Borentr shared the objectives of and selected findings from the OVC situation assessment done in Cambodia and the key

The following principles are embodied in Henan's policies: "child-centred;" equality and non-discrimination; participation rights of children; protecting the rights of children's development; and social responsibility. At the International Consultation on Orphans and Vulnerable Children held in Henan in September 2007, a policy brief was prepared that advocates for: the design of flexible and creative approaches to service provision that do not disclose the identities of children or households affected, where discrimination and stigma levels are high; the substantial roles of welfare, health, education, legal and security agencies in assuring that the needs of the "whole child" are addressed and that mechanisms to facilitate collaboration at all levels are explored and promoted; the provision of guidance and support to encourage the participation of young people to convey the "real situation;" and the design of innovative community actions to decrease stigma and discrimination as well as support children and households affected by AIDS.

In conclusion, Mr. Guangwei noted the need to pursue vigorously the following:

- Families, communities and welfare organizations need to improve further the welfare systems' services;
- Government guidance and social participation need to advance the development of children's welfare; and
- Government systems need to be standardized and specialized in order to improve the development of children's welfare in support of all vulnerable children.

components and costing of the NPA for OVC. He also explained some challenges, lessons learned and the next steps in Cambodia.

The OVC situation assessment and strategic planning had seven objectives:

1. To create a common understanding of the situation of OVC through a national situation assessment;
2. To map the current responses to OVC;
3. To define a national vision for OVC;
4. To strengthen coordination of the national response through developing a strategic framework and a three-year multi-sectoral action plan;
5. To accelerate scale-up of service delivery;
6. To facilitate resource mobilization through costing and analysis of current available resources and gaps; and
7. To advocate for the rights of OVC.

Mr. Borentr then provided some definitions of terms used in the study:

Orphan: a child below the age of 18 years who has lost one or both parents

Children affected by HIV: those children under 18 years

1. who are living with HIV,
2. who have lost one or both parents due to HIV,
3. whose survival, wellbeing or development is threatened or negatively impacted by HIV or
4. children living in affected families and/or families that have taken in children orphaned or displaced by HIV.

Other vulnerable children: those children under 18 years who are abandoned, street children living in extreme poverty, children of migrating families, victims of abuse, exploitation or neglect and violence, involved in child labour, using drugs and children of illicit drug users, or with disabilities (quoted from the Alternative Care Policy).

OVC data for Cambodia reveals the following:

- The number of orphaned children in households is estimated to be 553,000 or equivalent to 9 per cent of all children (CDHS, 2005), the majority of whom are paternal orphans while 1 per cent are double orphans;
- 16 per cent of orphans are aged 15 to 17 years;
- 6,121 orphans are living in orphanages (MOSVY, Alternative Care Report, 2007);
- 383,000 or 6 per cent of children are with chronically ill parents (CDHS, 2005);

- Approximately 3,800 children aged 0-14 years are living with HIV (NCHADS, Estimate and Projections, 2007); and
- There are 24,000 street children and other vulnerable ones.

CDHS data shows that the overall picture of orphaned children 0-14 years has changed a little from 2000 to 2005. The estimated population of OVC most in need of public assistance is approximately 1,690,000 or 27 per cent of all children. Nineteen per cent of orphans have grandparents as the head of household, and 8 per cent of orphans are adopted/fostered/not related to the head of household.

Showing some graphs, Mr. Borentr continued to analyse the situation of orphaned children in Cambodia. Children whose mothers are in the lowest wealth quintile (poorest children) have a three times greater risk of death than those whose mothers are in the highest wealth quintile (richest children) (CDHS, 2005). Children and adolescents in HIV-affected households are more likely to eat fewer meals and experience hunger more often than their peers in non-HIV-affected households (Alkenbrack, et. al., 2004). Among 13 to 17 year olds, orphans fare considerably worse than non-orphans in terms of school attendance, and this is true for boys and girls (CDHS, 2005). In general, girls have lower rates of school enrolment than boys, and this is more pronounced in girls affected by HIV. Maternal orphans are less likely to have birth registration or birth certificates available than children with living parents.

Discrimination and hunger are the two biggest predictors of psychological distress among children affected by HIV. Furthermore, female adolescents showed greater emotional problems and poorer relationship than male adolescents affected by HIV (D. Connel K, 2003). AIDS-affected households have significantly lower income than non-affected households (Alkenbrack et. al., 2004). HIV-affected households are spending much on health care and much less on other non-health expenditures when compared with non-HIV-affected households.

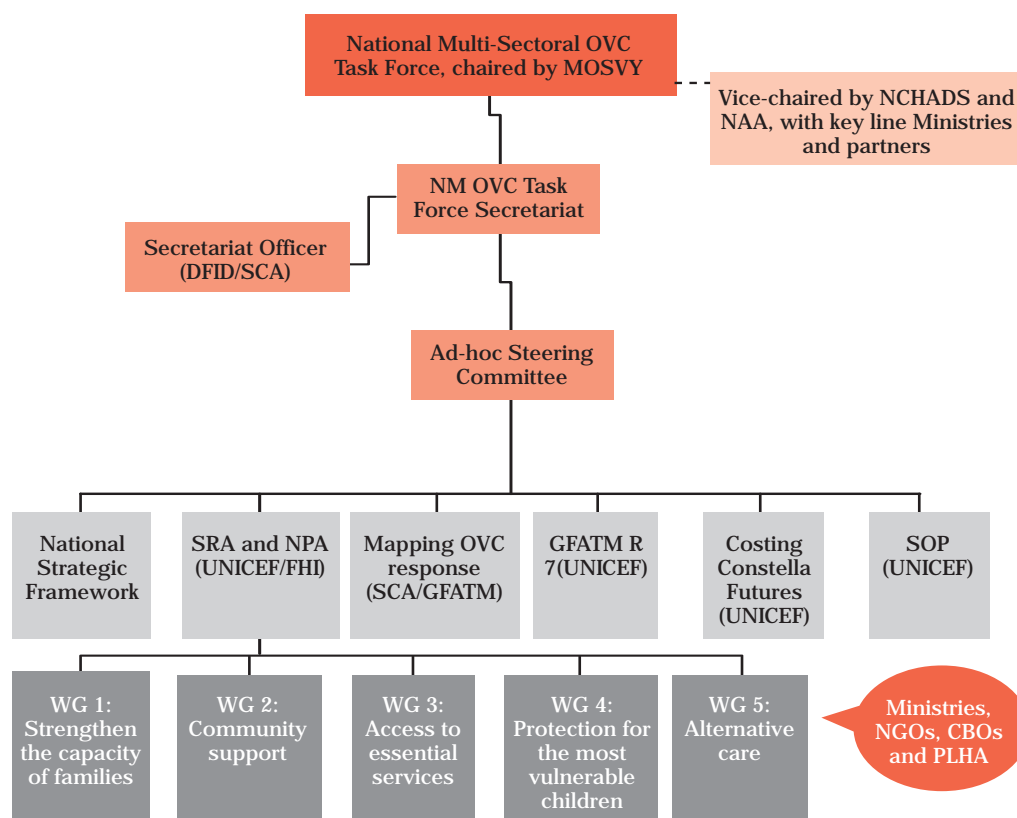
Mr. Borentr then discussed Cambodia’s 2008-2010 National Plan of Action for orphans, children affected by HIV and other vulnerable children. The Plan’s vision is a “Cambodian society where all children are provided with adequate protection, care and support to develop to their full potential in a supportive environment.” Its goal is to “strengthen coordination, systems, coverage and quality of services needed to mitigate the impact of HIV on the lives and futures of Cambodian children.” The Plan is guided by the Convention on the Rights of the Child and based on the following principles: to make a significant and lasting difference to the lives of children; to strive for gender equity; to

involve children; and to take a child-centred approach.

The Plan has five strategies:

1. Strengthening the capacity of families to protect and care for OVC;
2. Mobilizing and supporting community-based responses;
3. Ensuring access to essential services for OVC;
4. Enhancing the legal and policy frameworks for OVC; and
5. Creating a supportive environment for responding to OVC.

Figure 4: Coordination Structure at National Level:



The methods used in costing the National Plan of Action included a literature search, OVC unit cost survey (cost data collection from 39 NGOs and 19 government institutions) and a six-day participatory costing workshop. At the workshop, participants estimated the number of OVC, reviewed and fine-tuned minimum packages of services, calculated the national

average unit cost for each service and package, and costed services and NPA interventions based on population targets and unit costs.

Among the challenges and lessons learned from OVC initiatives and efforts are: obtaining a precise quantification of OVC because the

vulnerabilities are overlapping; finding a balance between covering all OVC and limiting the focus to HIV-affected children; balancing participatory and expert-driven methods when stakeholders are multiple and very diverse; coordinating a multi-sectoral approach; and keeping a focus on state responsibility.



Community-based efforts to protect children affected by HIV/AIDS in Myanmar

Aung Tun Khaing, Deputy Director General, Department of Social Welfare, Ministry of Social Welfare, Relief and Resettlement, Myanmar

Mr. Tun Khaing described the situation of orphans and vulnerable children in Myanmar. They are traditionally taken care of by the extended family. Other common practices include sending orphaned children to monasteries, to institutions under the Department of Social Welfare (DSW) or to private orphanages. In Myanmar, however, there is limited information to date about the specific situation of children who have lost their parents due to AIDS, and most available information is qualitative and not survey-based. While policy alternatives have yet to be developed, the Government encourages practices related to institutional care for orphans, such as fostering programmes, group homes and outreach/community support.

Myanmar is signatory to the Convention on the Rights of the Child. It enacted the Myanmar Child Law in 1993. The Minister of Social Welfare, Relief and Resettlement is the Chairperson of the National Committee on the Rights of the Child. Myanmar's National Plan of Action for Children (2006-2015) was developed in 2006 with the involvement of key stakeholders. In accordance with the NPA, Child Protection Programmes – including those for children infected and affected by HIV/AIDS – are being implemented with the aim of strengthening family and community-based activities in collaboration with UN agencies and I/NGOs. Under the Technical Strategy Group on AIDS, a sub-working group on orphans and vulnerable children was formed. Meetings are held on a regular basis.

Key next steps include developing a monitoring and evaluation plan and establishing a national data collection and monitoring system that captures service delivery for OVC; stepping up resource mobilization for OVC; and accelerating the implementation of the NPA.

The National AIDS Programme currently works with 10 partners to support OVC.

The DSW collaborated with UNICEF and other partners to conduct a study on the situation and needs of children affected by AIDS who are living in communities. The research interviewed 100 young people aged 14-19 years whose families were affected by AIDS, with a view to inform more effective programming.

Current programmes in Myanmar are benefiting over 15,000 children through the following interventions:

- Capacity building of project staff and volunteers on community- and home-based care activities for PLHIV, including affected and infected children, and on general knowledge and understanding of children, their needs and problems;
- Helping families protect and care for orphans and vulnerable children and ensuring equal access to essential services such as health, nutritional and educational support, emotional support, income generation, and livelihood advice;
- Organizing community-based responses to support affected families by forming community support groups to identify vulnerable children and families, their needs and by coordinating family care and support as well as referrals to services at the township levels when they are not available at the community level;

- Creating a supportive environment for all children through community awareness-raising and community networking and representative committees that involve community leaders, village elders, CBOs and school parents-teachers associations to deal with OVC as a community issue and to provide care and support; and
- Community self-help groups among PLHIV and family members of OVC to encourage peer and community support for OVC.

Key strategies to support children affected by HIV & AIDS include children's participation, empowering caregivers, involving the community and strengthening coordination among partners for appropriate response and referral to services, mobilizing and building the abilities of communities to respond to the impacts of HIV & AIDS on children, reducing community stigma and discrimination towards PLHIV and fulfilling the basic rights of orphans and vulnerable children.



**Caring for the whole family through family-centred care:
The Viet Nam Experience**
**Dr. Rachel Burdon, Senior Technical Officer, Care and Treatment,
Family Health International, VietNam**

Dr. Burdon provided background on the status of paediatric HIV and shared the successes and challenges in implementing the family-centred care (FCC) approach in Viet Nam.

In 2007, 8,500 children were estimated to be infected with HIV & AIDS in Viet Nam (VAAC, 2007). The number of children estimated to be affected by HIV & AIDS was 280,000. The latest estimate showed that there are approximately 1,200 children on ART (VAAC, 3/2008). It is unknown, however, as to how many children are enrolled in HIV care/support.

Family-centred care is a set of systems and services that enable coordinated HIV care for families. It addresses comprehensive needs (care, treatment, support, protection and prevention) of the whole family, adults and children. It cares for parents/caregivers and

Some challenges that remain include strengthening psycho-social support to help children cope with parents' dying or death; strengthening caregivers' skills and knowledge to support families and children affected by HIV & AIDS in their communities; the difficulty of fostering arrangements due to stigma and discrimination, especially if children are not healthy and could not help in the household; and the inability of guardians to take care of children due to economic constraints.

For 2008 and beyond, Myanmar will move away from issue-based programming to targeting all vulnerable children in a given community; increase its focus on caregivers' skills in providing psycho-social support to children; explore other community-based care options, including small group homes in the community for children rather than institutionalization; identify a minimum care package with partners; and work to better understand the situation and needs of OVC in institutions.

children living with and affected by HIV/AIDS together as much as possible. It uses a case management approach to plan and provide comprehensive and effective HIV care for families.

Why FCC makes sense

Families affected by HIV may need to go to many different services for prevention, care, treatment and support: adult HIV OPC; paediatric HIV OPC; under-five clinic; TB services; in-patient services; social work services; PMTCT services; and/or tertiary referral services. This can lead to poorly coordinated, complicated, costly and fractured care for families – i.e. the 'important needs' get missed. Families are often forced to make decisions about who should be the priority for receiving care.

We need to enroll infants/children into care and treatment as early as possible.

A high mortality rate in the first few years of life means we need to identify HIV-infected children and intervene early. Interventions include feasibility of Early ARV Treatment (CHER trial), cotrimoxazole prophylaxis, growth monitoring and developmental screening, feeding counselling and nutrition support, and routine under-five care including immunization.

We need to keep mothers well to keep children well.

The deaths of HIV-exposed infants are associated with maternal HIV disease. Thus, improving maternal health improves infant survival (Newell ML et. al., Lancet, 2004+364-1236-43). Irrespective of HIV-infection status, all children whose mothers had AIDS or died were at considerably higher risk of death.

Families affected by HIV have multiple needs in addition to HIV care and treatment, namely: psychological support; educational and developmental growth; nutrition; protection; mitigation of stigma and discrimination; income generation, vocational training and employment opportunities; assistance with substance abuse; access to prevention; and reproductive health services.

How did FCC evolve in Viet Nam?

In 2005, HIV care services in Viet Nam were initially adult-oriented. The small number of children accessing services had to travel to tertiary referral services. In 2006, there was an impetus for change as there were noted increases in numbers of parents/caregivers bringing children into the clinics for care, of children in need of care, and of orphans and vulnerable children being identified. Also, health workers were distressed at not being able to offer HIV services to children. Multiple psycho-social needs of families were being identified. At the same time, the global international climate started strongly advocating for the scale up of interventions for the protection, care and support of children affected by AIDS.

How did FHI go about it?

FHI implemented five integral components of FCC:

1. Re-orienting clinical HIV services to provide HIV care for families so that paediatric HIV care and PMTCT were integrated into adult HIV clinics (paediatric formulations, training, job aides and tools and mentoring);
2. Establishing the role of Family Care coordinators/case managers to assess and support psycho-social needs of families, children and parents and caregivers (counselling, protection, food, transport, schooling and IGA);
3. Re-training community and home-based care teams to assess and respond to the needs of the whole family – both adults and children – including case detection, referral, spiritual support and nutrition;
4. Linking clinical services with the Government, NGOs and CBOs to provide social support, IGA schemes, nutrition and child protection services; and
5. Advocating/developing skills to implement the FCC approach for advocacy, capacity building, new or linked clinical care record systems, mentoring and QA/QI.

Care services for families provided at the FCC clinic include physical care, emotional/spiritual support, social support and protection for adults and children, and cognitive development for children. Physical care includes OI care and prophylaxis, palliative care, ART, adherence support for cotrim oxazole prophylaxis, ART and TB, PMTCT, growth monitoring and nutrition support, immunizations and general health status.

Emotional/spiritual support involves the assessment of emotional well-being and lay counselling and support, and succession planning, all of which help children stay in a family environment. Social support and protection have to do with linking to government social welfare funding, linking families to income generation activities, preventing abuse and identifying and caring for children who have been abused. Cognitive development for children includes play and educational opportunities for children 3-17 years, training of parents in care-giving skills and child development, and schooling support.

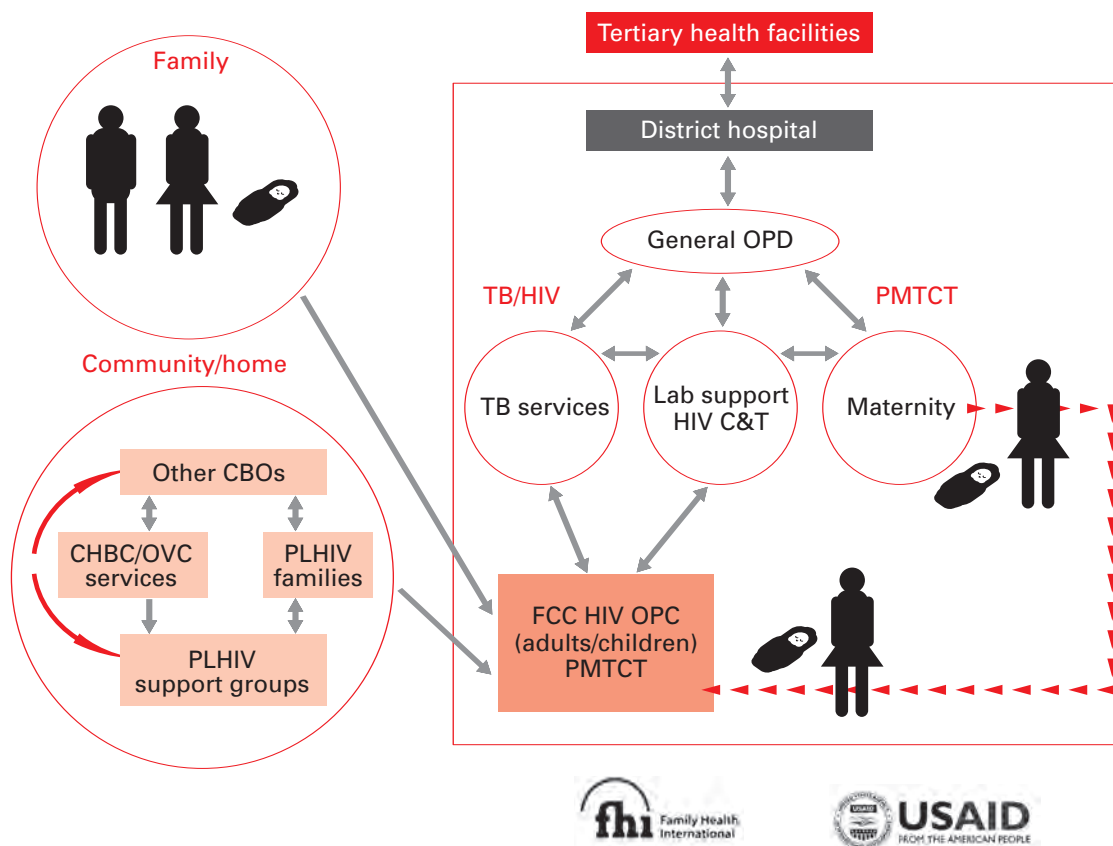
What has been successful ...

District-level HIV services are now providing coordinated, comprehensive HIV care for families in Viet Nam. Adult HIV doctors have been very willing to take on paediatric HIV care and treatment. Quality of paediatric care and treatment was reported high by external QA/QI. ART was made available to children who might not be able to access otherwise. FCC coordinators have increased the counselling/testing of children and have increased uptake of OVC. Furthermore, some children successfully re-enrolled in school. Lastly, the Viet Nam MoH, GFATM and PEPFAR partners are currently scaling up paediatric care at the district level.

What remains challenging...

Dr. Burdon noted that second-line paediatric medications remain expensive and are currently not prescribed at the district level. There is a need to strengthen child communication and counselling, PMTCT and nutrition and economic support for OVC and infected children. It is also important to access 'Most at Risk' and vulnerable families, to integrate family planning into HIV services, to explore alternatives to institutional care for HIV-infected/affected and to address stigma and discrimination.

Figure 5: Family-centred care in the continuum of care



Discussions

- **On 'conditionalities' and guidelines for cash transfers:** Conditional cash transfers are often tied to immunization and school attendance. In some countries, the programme administrator must do things first before the programme is received; others, however, do not set any condition. Nonetheless, there is no evidence to prove that conditional cash transfer programmes are more effective than unconditional transfer programmes, i.e. that setting

conditions would make any difference in outcomes. For example, in terms of school attendance, nutrition, etc., we see the same outcomes from programmes with and without preset conditions. It is not clear if conditions are needed. What is more important is the best interest of the child.

In cash transfers, measures and outcomes should be the same. We expect to see outcomes in terms of reducing poverty, improving access to education and health care, among other improvements. Also, we should measure impact based on gender.

Few cash transfer programmes are linked to HIV & AIDS. They are usually not linked to any particular medical status because of stigma attached to it. Focusing more on universal approaches is more effective.

- **On simulation parenting:** A participant from China explained that simulation parenting is when the government hires a family to foster a child.
- **On the institutionalization of orphaned children:** Cambodia does not encourage the care of OVC in orphanages but care by the community instead. In the case of the institutionalization of children in orphanages, minimum standards have been developed. Support of family and community is one key strategy incorporated in Cambodia's National Plan of Action. Myanmar's National Plan of Action supports alternative care. Its Department of Social Welfare is working with UNICEF on reintegrating children into families and communities, but it is still a work in progress.

Day Two: 1 April 2008

Session 4.

Evidence-based approach: Progress made since Hanoi



Estimation, monitoring and evaluating the response to children affected by HIV and AIDS in EAPRO

Dr. Priscilla Akwara, Statistics and Monitoring Section, Division of Policy and Planning, UNICEF, New York

“Simply put, strengthening M&E is a country-led process that seeks to harmonize M&E, build capacity and operationalize a monitoring and evaluation system.”

Dr. Akwara’s presentation was divided into four main parts:

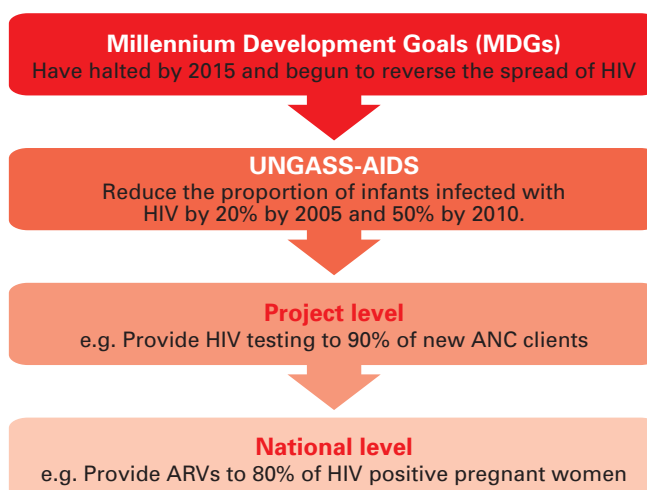
- Global and national goals and indicators for children affected by HIV & AIDS;
- Estimation and projection of children affected by HIV & AIDS;
- Challenges to monitoring the progress towards targets for children affected by HIV & AIDS; and
- Steps to strengthen M&E of children affected by HIV & AIDS.

All countries are committed to reaching the UNGASS and MDG indicators by 2015 and the

UNGASS target of reducing the number of infants with HIV by 2010. UNGASS uses 29 indicators. Most countries are far away from achieving these goals. Countries, however, also need to set their own targets. Often UNAIDS assists in facilitating the setting of these targets. By measuring outcomes and impacts, progress is being measured.

The April 2007 Framework for Monitoring and Evaluating HIV Prevention Programmes for Most at Risk Populations describes M&E methods and provides 13 core indicators and additional indicators for programme monitoring. The framework describes data collection methods, gives examples of the use of data for programme planning and monitoring, and provides references for additional technical information.

Figure 6: Global and national goals and indicators



The 29 UNGASS HIV M&E indicators include 8 indicators on most-at-risk populations, 2 on national commitment and action, 9 on national programme coverage, 10 on knowledge and behaviour, 4 on impact and 4 on global commitments and action. These indicators are for both generalized and concentrated/low prevalence epidemics, and countries can apply any indicators that are relevant to their situation. There should, however, be emphasis on disaggregated data by sex, age and sub-populations.

Guidance for HIV prevention programmes provides a description of M&E methods for most-at-risk populations. This includes most-at-risk adolescents, 13 recommended core indicators, additional indicators for programme monitoring, a description of data collection methods, examples of use of data for programme planning and M&E, and references for additional technical information.

Global efforts at harmonization have led to M&E guides for national programme monitoring, which include agreement on indicators among donors and other agencies, and guidance for countries on useful indicators to facilitate data comparability. There are existing guides for monitoring and evaluating the affect of HIV on children, particularly orphans and vulnerable children, infants and young children (prevention of mother-to-child transmission), young people, antiretroviral therapy, care and support, and testing and counselling (under development). Other guidance includes additional national programme indicators, which are an addendum to the 2008 UNGASS monitoring guide (under finalization), and various technical guidelines on setting national and programme targets, surveillance surveys and estimations of population size.

Current mechanisms to monitor targets for children affected by HIV and AIDS include the following:

- Estimates are produced every two years from statistical models (e.g. Spectrum software) using specific assumptions and in conjunction with or by national programmes, with UNAIDS/WHO using standard procedures and software. Revisions have been made to 2005 estimates for 2008 UNGASS reporting.

- National Survey-based indicators are approved by national programmes before release roughly every 3-5 years. These could be general population-based or targeted surveys for specific sub-populations at risk (DHS, MICS, BSS).
- Service provision and surveillance programme statistics are produced by national programmes in conjunction with implementing partners.
- Censuses are made from complete enumeration of national population.
- Administrative registration records are collected e.g. on births and deaths.
- Special research studies include efficacy, survival rates, resistance, etc.

Groups involved with the estimation of children affected by HIV & AIDS in East Asia and the Pacific are the National AIDS Council or the Ministry of Health at the country level, the UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, and the UNAIDS Reference Group on Estimates, modeling and Projections that gives advice on methodology.

In working with countries, regional training workshops were conducted in 2003, 2005 and 2007 (February-June) in Sub-Saharan Africa (4), Asia (2), Latin America (2), Caribbean, Eastern Europe and Central Asia, North Africa and the Middle East. Partners included WHO, UNICEF and the World Bank (2007).

In finalizing country-estimates for 2007, the following activities were undertaken: an exchange of country data and files between country teams and the UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance; review and discussion; inclusion of additional data and an agreement on estimates for publication in the Report on the Global AIDS Epidemic (July-August 2007).

One estimation method was the use of Spectrum Software to generate data on new infections, HIV-positive populations, AIDS deaths and the need for treatment, and orphans. New types of information for estimation involve treatment options for adults (1st and 2nd line ART) and children (ART and cotrimoxazole) and tracking the progression

periods from new infection to the need for treatment and then to AIDS death, with or without treatment; expanded PMTCT treatment options; calibrating to multiple national surveys and uncertainty analysis to determine the range within which true values lie.

Spectrum inputs required:

Country data

- Demographic data
- Adult prevalence
- MTCT programme description
- PMTCT coverage
- Adult ART coverage
- Child treatment coverage

Epidemic patterns

- Effect of HIV on fertility
- Progression from infection to need for treatment to AIDS death
- Sex ratio of prevalence
- Age distribution of infection
- MTCT rates by regimen and feeding options
- Effect of child treatment – ART and cotrimoxazole

The following shows the high-risk groups and the potential sources of prevalence data:

Groups:	Sources of data:
IDUs	DHS Surveys
MSM	Capture-recapture studies
FSW	High-risk group surveillance
Clients of FSW	Census studies

On the other hand, populations at lower risk and potential sources of prevalence data are:

Groups:	Sources:
Sex partners of IDUs	Published estimates
Sex partners of MSM	Calculated with assumptions
FSW	DHS
Sex partners of clients of FSW	Census surveys, STI (?)

Among the **challenges of monitoring and evaluation** of progress towards targets for children affected by HIV and AIDS are:

- Lack of supportive environment to foster free access and use of services for most-at-risk populations, thereby hindering the collection and use of data – legal, political, social, institutional, etc

- Poor coordination and management of M&E efforts between governments and implementing partners and amongst partners themselves, which make it difficult to get a complete picture of the national response
- Limited or no specific allocation of resources for data collection, analysis and use of data
- Lack of strong political will, commitment and leadership
- Fear and reluctance to share data between and across government and partners, since HIV data are considered sensitive
- Limited use of data to support evidence-based decision-making
- Lack of harmonization of indicator definitions and data collection and analysis methods negate data comparability – different age groups, different denominators, different geographical study sites over time and sub-populations
- Data collection, reporting and management issues:
 - Fragmented data collection processes – within the government, between government and partners and amongst partners themselves
 - No clearly defined data reporting structures – a culture of ‘ad-hoc’ or crisis-driven M&E
 - Lack of centralized data management systems leading to difficulty in data retrieval and use and no complete picture of the national response
- Poor quality of coverage/service statistics and lack of mechanisms to validate and harmonize data, resulting in incomplete data and differing values
- Limited disaggregated data – sex, age, sub-populations at risk
- Ethical issues in studying children <15 years
- Estimation of population size in low/concentrated epidemics as problematic, particularly ‘hard-to-reach’, hidden, marginalized, mobile or migrant populations
- Difficulty in the preparation of national-population size estimates for each risk group
- Prevalence may be measured in easy-to-reach populations that may not be representative of the entire population in that risk group

One response is to use uncertainty analysis to generate ranges around the median estimates.

To **strengthen monitoring and evaluation**, the following steps are needed:

- Establish a country-led process, by identifying a government institution to be responsible for coordinating and managing the process.
- Identify common focus areas for measurement and collaboration among stakeholders using an inclusive, consultative and participatory process involving all key stakeholders (government, NGOs, CBOs, people living with HIV, most-at-risk sub-populations, etc).
- Harmonize indicators and data collection at every level of implementation and be consistent with national and international reporting standards – One M&E framework (“Three One’s” principles).
- Develop and pilot M&E systems, including data collection, reporting and monitoring guidance, tools and data repository system.
- Build the capacity of implementing organizations to strengthen project-level systems to routinely capture, report, share and use data.
- Integrate processes into existing M&E systems, as far as possible.
- Develop clear M&E data flow structures at all levels, with specific reporting and feedback timelines and guidelines.
- Enhance sharing of data among all key stakeholders at all levels (national, sub-national and project levels) by establishing platforms for regular review of progress, sharing of data and best practices.
- Evaluate programmes and interventions to better understand outcomes and impact, and develop an evaluation and research agenda.



Children and families affected by HIV & AIDS in Indonesia
Dr. Haniff Asmara, Director of Social Services for Children, Ministry of Social Affairs, Indonesia

Dr. Asmara discussed the findings in Indonesia from an impact assessment of HIV at the household level and from a review of existing government policies and programmes. He concluded his presentation with some insights, recommendations and future plans of action.

The impact assessment of HIV used both quantitative methods (household surveys of 693 ‘index’, meaning affected, households and 691 ‘reference’, meaning non-affected, households) and qualitative methods (focus group discussions and in-depth interviews). The assessment covered two districts/municipalities in each of seven selected provinces, as follows:

1. DKI Jakarta: Central Jakarta and North Jakarta
2. Papua: Jayapura Municipality and Merauke District
3. East Java: Surabaya Municipality and Malang Municipality

4. West Java: Bandung Municipality and Bogor Municipality
5. Bali: Denpasar Municipality and Badung District
6. West Kalimantan: Pontianak Municipality and Singkawang District
7. North Sumatra: Medan Municipality and Toba Samosir District

Respondents from both index and reference groups had almost the same economic status: the majority of them are poor, with 17.75 per cent living below the poverty line (BPS).

Many PLWHA had disclosed their HIV status to parents (67.2 per cent), an NGO (57 per cent), spouse (46 per cent), sibling (45 per cent), and/or a support group (45 per cent). Discrimination against PLWHA remains high, with household members or the community blaming them for their status.

The majority of caregivers, from both index (89 per cent) and reference (95 per cent) groups, is female. Overall, the child caregiver's knowledge on care-giving (psycho-social aspects) among index is lower than among reference.

In terms of orphan status of sampled children in households, index had more orphans than reference (17.5 per cent vs. 4 per cent), and more paternal orphans (11 per cent vs. 3 per cent). On socio-economic impact to households, index shows financial deficit, i.e. savings are smaller than debt and financial burden was perceived as worsening. School drop-out in index is higher. The ability to continue study/education (as perceived) is lower in index than in reference, owing to lack of financial resources. Children in index also have higher morbidity and experience more hospitalization, more self-treatment, and have less access to *askeskin* (health insurance). They experience higher anxiety and lower self-esteem and tend to engage in more risky behaviour than the reference.

In terms of the percentage of children working, there is no significant difference. The kind of work, however, done by children affected by HIV is different (children in index often resort to vending or begging). Furthermore, children in index are less likely to be engaged in sports, reading and the activities of religious groups. They also feel more undermined and more harassed at school, they are refused by health personnel and excluded by friends.

As coping strategies by families, more in index than in reference sell valuable goods and borrow money from family, and adults work harder. Caregivers are usually grandparents, uncles/aunts, siblings or other relatives because blood relations are expected to be responsible for care, and there may also be religious motives and obligations. The basic needs of children in index are less fulfilled compared with those in reference – they have less clothing, school reading materials and support for school tasks. While those in index receive higher health and food insurance and other forms of support (34 per cent) compared with those in reference (20 per cent), they receive less support for child education,

training, counselling and spiritual guidance, including from support groups. More in index receive support from NGO (43 per cent), while more in reference obtain support from the government (69 per cent). The forms of support requested by index are care and support, finance, home care and support groups.

Dr. Asmara proceeded to discuss the functions and activities of the different structures within the Government of Indonesia that are involved with the HIV & AIDS response. The **National AIDS Commission (NAC)** developed the National Plan of Action 2007-2010, a national-level policy for children in Papua with a focus on impact mitigation of HIV & AIDS, including a few local regulations specifically for children affected by HIV & AIDS.

The **Ministry of Health** is responsible for prevention (PMTCT, communication campaign, condom distribution, harm reduction, STD management, blood-donor security and universal precaution), services (VCT, ARV, opportunistic infection, nutrition, palliative treatment and care, laboratory, case management, home-based care and hotline services), supporting efforts (surveillance, estimation, costing, research and development, regulation and law, training and education), and health insurance for the poor (*askeskin*).

The **Ministry of Social Affairs** is involved with family-based care, alternative care and institution-centred programmes for children in need of specific protection, including addressing the rights and needs of the child, promoting the responsibility of parents, family, community and government for the child; reunification; family support; shelter, care and training for people with social problems; and loans for small investments.

Other sectors include the Ministry of National Education, which is responsible for HIV prevention education in school and the provision of educational support for school operational matters (BOS); the Ministry of Agriculture, which provides rice (*raskin*); the Ministry of Internal Affairs, which supports implementation of national-level policy at provincial and district levels; and the National

Planning Board, which acts as the Coordinator for planning and budgeting.

The **NGOs** also deal with HIV and AIDS issues and provide the following: prevention/PMTCT, communication and social mobilization campaigns, advocacy, condom distribution, harm reduction and STD management; services like VCT, care, support, case management, home-based care and hotline service; and capacity building. NGOs have strong links with stakeholders at the village or district levels.

To address the negative socio-economic impact of HIV and AIDS on households and children, the following are recommended:

- On PLWHA's poor condition and low access to support: to increase support for the poor regardless of HIV status; to strengthen existing schemes for identifying the poor at the village level and to strengthen coordination between government sectors and other organizations providing support
- On child morbidity: to increase hospitalization and cash payment to increase coverage of health insurance for the poor and for NGOs to assume a greater role towards ensuring access to health services
- On higher incidence of school drop-out owing to lack of financial resources: to increase support for schools (BOS) and for community social workers to support, facilitate and ensure access to essential services for all children
- On psycho-social impact on the child (anxiety and low self esteem, high-risk behaviour such as smoking, low psycho-social knowledge of child caregivers): to implement life-skills education in and out of school and to conduct training for child caregivers on child care, including psychosocial aspects

Dr. Asmara also provided policy and programme recommendations for specific government agencies: the National/Provincial AIDS Commissions at provincial and district levels to develop a comprehensive local regulation with respect to children; the National/Provincial Planning Board (Bappenas and Bappeda) to establish a coordination mechanism among sectors providing support for families and children in need; and the Ministry of Social Affairs to implement and enforce the existing policy for children in need of specific protection and to establish a surveillance system for children in need of specific protection.

The future plans of action for 2008 include the following:

1. For the National Planning Board (Bappenas) to establish a coordinating mechanism among sectors providing support for families and children in need of specific protection, to guide the development of the National Plan of Action for vulnerable children (including orphans) in collaboration with other sectors, and to include a specific line item in every sectoral budget to ensure sustainability and monitor budget allocation and expenditure
2. For MoSA (Departemen Sosial) to implement family- and community-based care and support programmes in seven provinces, together with partners and guided by the assessment, and to pilot a surveillance mechanism for children in need of specific protection in three cities
3. For the national university to undertake research



Evaluating needs of children affected by AIDS and their policy implications

Dr. Yuan Jianhua, Senior Fellow, Beijing Institute of Information and Control, China

Dr. Jianhua shared the objectives, key findings and policy implications of the household survey undertaken in three selected sites. The methods used were household surveys of non-affected and affected populations, including interviews of children in one city and two counties in China. The following shows the sample distribution.

Table 1: Sample Distribution of 3 Counties in China

	Non-affected		Affected	
	Number of Households	Number of Children	Number of Household	Number of Children
County A	101	135	100	169
County B	100	144	88	183
County C	40	94	60	94

Among the key findings are as follows:

- On income: Households affected by AIDS have significantly lower income than households not affected. Without external assistance, income of the affected households is only 45 per cent that of the unaffected on average.
- On living conditions: Even with the current assistance, differences remain in clothing and food between affected and non-affected children. Meat consumption is less among affected than non-affected households in all three areas. There is a lesser number of affected than non-affected households who have three pieces of new clothes in the past year.
- On education: There is no difference between enrolment for the affected and non-affected children among children aged 7-15. Neither the affected nor the non-affected teenagers are receiving much vocational skills training.
- On utilization of health services: The health service utilization rate of children affected

by HIV/AIDS is higher than the non-affected children in areas where health assistance is provided.

- On psychological health: Disparities in psychological well-being exist between children affected by AIDS and those not affected. However, differences also exist among the various indicators on psychological health among the three areas. Out of a set of ten indicators, children affected in City A indicated they had problems in five areas (mood, future orientation, self-esteem/self-worth, externalizing behaviour and social connection and capacity), in County B they had problems in one area (mood) and in County C they had problems in five areas (stress and worry, mood, self-esteem/self-worth, externalizing behaviour and social connection and capacity).

Below are the policy implications of the assessment findings:

- On financial support: It is necessary to promote direct cash assistance to families affected by AIDS to close the income gap between the affected and the non-affected.
- On improvement of living conditions: In addition to cash assistance, periodic material assistance (food, clothing etc.) is necessary.
- On education support: There is a need to strengthen the education assistance of teenagers older than 15. Vocational skills training in rural areas provides more opportunities for children and teenagers.
- On health assistance: This should be provided in addition to financial support.
- On psychological support: Strengthen psychological support, including routine visits, talking, organizing participatory activities, etc. Not only financial assistance is necessary, but also other forms of support should be included.



HIVQUAL-T: Improving the quality of HIV care with a clinic-based initiative

Dr. Kimberley Fox, Director, Global AIDS Program Center for Disease Control (CDC), Southeast Asia Regional Office

“The magnitude of the HIV epidemic and the complexity of treatment make quality assessment of HIV care essential.”

Dr. Fox’s presentation began with a brief description of the HIV & AIDS situation in Thailand. In 2006, there were an estimated 540,000 adults and 16,000 children living with HIV infection. HIV care services are provided as part of the national antiretroviral treatment programme. In 2007, approximately 133,000 adults and 7,000 children received ARVs.

As care is being provided in an increasing number of hospitals, a key question is how can the quality of HIV care services be ensured? To address this concern, the HIVQUAL-T project was initiated.

HIVQUAL-T is an initiative for performance measurement and quality improvement in Thai outpatient HIV clinics. HIVQUAL-T is modelled on the U.S. National HIVQUAL Project developed by the New York State Department of Health AIDS Institute and supported by the Health Resources and

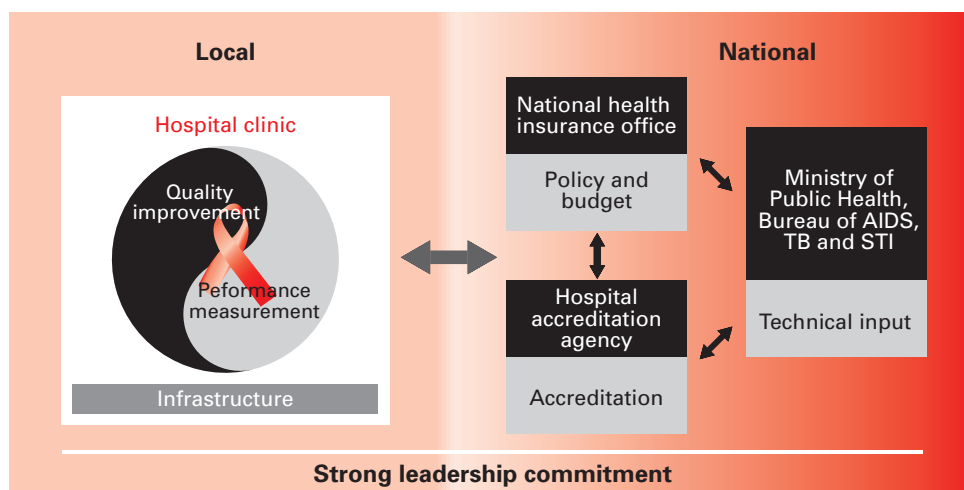
Services Administration (HRSA). The HIVQUAL model has three core components:

- Performance measurement,
- Quality improvement and
- Infrastructure development.

These three components are integrated, and the activities occur as a continuous process.

In terms of processes involved in performance measurement, HIVQUAL-T indicators are first defined based on national guidelines and other standards of care. Then a case list is produced of eligible patients who received HIV care at each clinic during the calendar year. Criteria for eligibility are HIV-positive status, paediatric and adult age criteria and at least two visits for HIV services during the calendar year. From this, a sample is randomly selected. The sample size is calculated to achieve precision of +/-8 per cent within a 90 per cent confidence interval. Data on the selected HIV outpatient care indicators are then abstracted from patient records and entered into the software. Indicator reports are automatically generated immediately following data entry.

Figure 7: Model for sustainable QI System in Thailand



After the HIVQUAL performance measurement, hospitals use the results to develop quality improvement (QI) activities. Hospital QI committees are responsible for reviewing the indicator reports from their own data and overseeing the planning and implementing of QI activities. Performance measurement is then repeated to see if indicators have improved. The hospitals learn from each other through regional meetings where they share experiences and compare results. The following is an example of a paediatric HIVQUAL-T QI activity to increase the proportion of children receiving immunization history assessment. After collecting performance measurement data, the paediatric HIVQUAL-T team reports paediatric HIVQUAL-T data to all clinic staff at routine meetings. Immunization guidelines are given to health providers. Patients are asked to bring their vaccination book to every clinic visit. And finally, an immunization variable is added to the medical record form.

Results of paediatric HIVQUAL-T PM from five hospitals, with 460 patients in 2005 and 435 in 2006, were selected for chart abstraction. There was high coverage for most indicators at the baseline, including clinical monitoring, CD4 monitoring, ARV treatment and adherence monitoring. Viral load (VL) monitoring – an optional indicator – is a bit low, but that is not surprising since it was not part of the national guidelines for HIV care. The five hospitals also found high coverage for PCP prophylaxis, clinical TB screening and oral health assessment. MAC prophylaxis and CMV retinitis screening are not included in the national guidelines for all patients, which is probably why the coverage was so low for these indicators. However, QI projects were implemented for all five indicators that fell below 80 per cent, including the immunization history. There was a significant increase in performance of all these indicators.

The hospitals also found high coverage for growth assessments and school attendance, but low coverage for developmental assessments, secondary sexual characteristic assessments and disclosure. QI projects were implemented for developmental assessment and secondary sexual characteristic assessment, and there was a substantial increase in these indicators. However, HIV

disclosure still needs improvement. This is an example of how HIVQUAL-T results are used for benchmarking – that is, comparing results among hospitals. More than 90 per cent of patients received adherence assessments in 2005 in all hospitals except Hospital D. Results were shared so that hospital staff could compare their performance with others. This helped Hospital D to determine that adherence assessment should be a priority area for QI, and adherence assessment in this hospital did increase after a QI activity.

Lessons learned from HIVQUAL-T implementation

- Despite national guidelines, coverage for some key aspects of HIV care was low prior to QI activities. Training, guidelines and resources do not ensure the quality of care.
- QI infrastructure and approach were integrated in routine hospital systems. QI minimizes the resources needed, improves planning, communication and teamwork, and builds capacity of hospital staff for QI in other areas of care.
- Hospital-based performance measurement data were effectively used for quality improvement. The HIVQUAL approach focuses on using data to improve programmes. Quality was monitored during the national scale-up, so problems could be corrected early. Peer learning and benchmarking helped motivate hospitals to improve their quality of HIV care.
- Performance measurement can be integrated into larger programme monitoring and payor systems. While HIVQUAL is not a programme monitoring system (does not monitor overall programme outputs), the HIVQUAL performance measurement data complements programme output data and can be automatically produced by patient-level electronic databases if appropriately designed.

In conclusion, the HIVQUAL-T model has been successful in developing local capacity for quality improvement, including analysis of performance data and development of quality improvement initiatives. This has led to higher quality HIV care for people in Thailand. This model for quality improvement in HIV care may be of interest to other countries as well.

Next Steps: Continued expansion of HIVQUAL-T in Thailand

The HIVQUAL model was adapted and implemented in Thailand beginning in 2003, starting with adult HIV care. As a result of the successful pilot implementation, GAP Thailand, along with the National Health Security office and the MOPH, expanded HIVQUAL from 12 hospitals in 2004 to 140 hospitals in 2007. National scale-up of the adult module to all of the country's 961 hospitals is expected to be completed in 2008. The paediatric and

additional modules were developed in 2005-2006. Expansion of the paediatric module is planned with integration into adult HIVQUAL-T in 2009-2010.

Because of the success of HIVQUAL-T, GAP/Thailand staff have helped Uganda to develop the HIVQUAL-U software (both adult and paediatric) and provided technical assistance for paediatric HIVQUAL-U indicator development and implementation, in coordination with the New York State Department of Health and UNICEF.

Discussions

On costing recommended policies and programmes: In Indonesia, the National Planning Board calculates the costs based on available data and recommended actions. It plans for an evaluation following the plan of action. Concerned sectors implement the programme. All ministries have specific responsibilities in addressing HIV & AIDS. They recognize the need to specify budgetary requirements and to advocate for budgetary support. In China, there are lots of programmes for children affected by HIV & AIDS, some of which are included in the programme design. This year, it plans to evaluate and cost these programmes.

On sampling selection: In China, 'affected children' are defined as children at least three years old, whose parents may or may not be HIV infected. The evaluation team conducted interviews of affected households around the neighbourhood. One sample site is a UNICEF site (with programmes supported by UNICEF), another is supported by the local government, and the last site implements programmes but not specific to children. In Indonesia, a sample is randomly selected from a list of HIV & AIDS cases.

Session 5.

Preventing infection among young people



Provider-initiated testing and counselling (PITC) for low prevalence and concentrated epidemic settings

Kathleen Casey, Regional Senior Technical Officer, Family Health International Asia-Pacific

“Voluntary testing is more likely to result in behaviour change to avoid transmitting HIV to other individuals.”

Ms. Casey started her presentation by defining some key terms in HIV counselling and testing:

- Voluntary counselling and testing (VCT) involves individuals actively seeking HIV testing and counselling at a facility that offers these services. Client-initiated HIV testing and counselling usually emphasizes individual risk assessment and management by counsellors, addressing issues such as the desirability and implications of taking an HIV test and the development of individual risk reduction strategies. Client-initiated HIV testing and counselling is conducted in a wide variety of settings, including health facilities, stand-alone facilities outside health institutions, through mobile services, in community-based settings and even in people’s homes.
 - Diagnostic HIV testing is indicated whenever a person shows signs or symptoms that are consistent with HIV-related disease or AIDS to aid clinical diagnosis and management. This includes HIV testing for all tuberculosis patients as part of their routine management.
 - Routine offer of HIV testing by health care providers should be made to all patients who are:
 - Assessed in a sexually transmitted infection clinic or elsewhere for a sexually transmitted infection, in order to facilitate tailored counselling based on knowledge of HIV status;
 - Seen in the context of pregnancy to discern if there needs to be an offer of antiretroviral prevention of mother-to-child transmission; and
 - Seen in clinical and community-based health service settings where HIV is prevalent and antiretroviral treatment is available (injecting drug use treatment services, hospital emergencies, internal medicine hospital wards, consultations, etc.) but for patients who are asymptomatic.
 - Mandatory testing for HIV and other blood borne viruses of all blood that is destined for transfusion or for manufacture of blood products is supported by UNAIDS/WHO. Mandatory screening of donors is required prior to all procedures involving transfer of bodily fluids or body parts, such as artificial insemination, corneal grafts and organ transplants. UNAIDS, WHO and FHI do not support mandatory testing of individuals on public health grounds.
- HIV testing without consent may be justified in the rare circumstance in which a patient is unconscious, his or her parent or guardian is absent and knowledge of HIV status is necessary for the purposes of optimal treatment on a mandatory basis. Some countries conduct mandatory testing for pre-recruitment and periodic medical assessment of military personnel to establish fitness. UNAIDS and WHO recommend that such testing be conducted only when accompanied by counselling for both HIV-positive and HIV-negative individuals and with referral to medical and psychosocial services for those who receive a positive test result.

Targeted by the PITC strategies are the most-at-risk populations (MARPs). The Report of the Commission on AIDS in Asia (March 2008) refers to the following as MARPs:

- Sex workers (SWs) and clients
- IDUs (sharing needles and syringes; unprotected sex)
- MSM and transgenders (unprotected sex)
- Sexual partners of MARPs
- Infants born to MARPs
- Migrant workers (in some contexts)

Ms. Casey explained the processes involved in PITC implementation:

1. A doctor simply suggests or requests the test from a counsellor (pre-test counselling) or group pre-test information.
2. The doctor suggests the test, provides brief minimal information (usually not more than five minutes to be realistic) and also gives the result. Doctors need brief training on how to do this sensitively in a time efficient way.
3. The doctor suggests the test be discussed briefly and for the counsellor to give the results. The counsellor and doctor need to be trained in different ways. Doctors need a brief training on how to offer HIV testing.

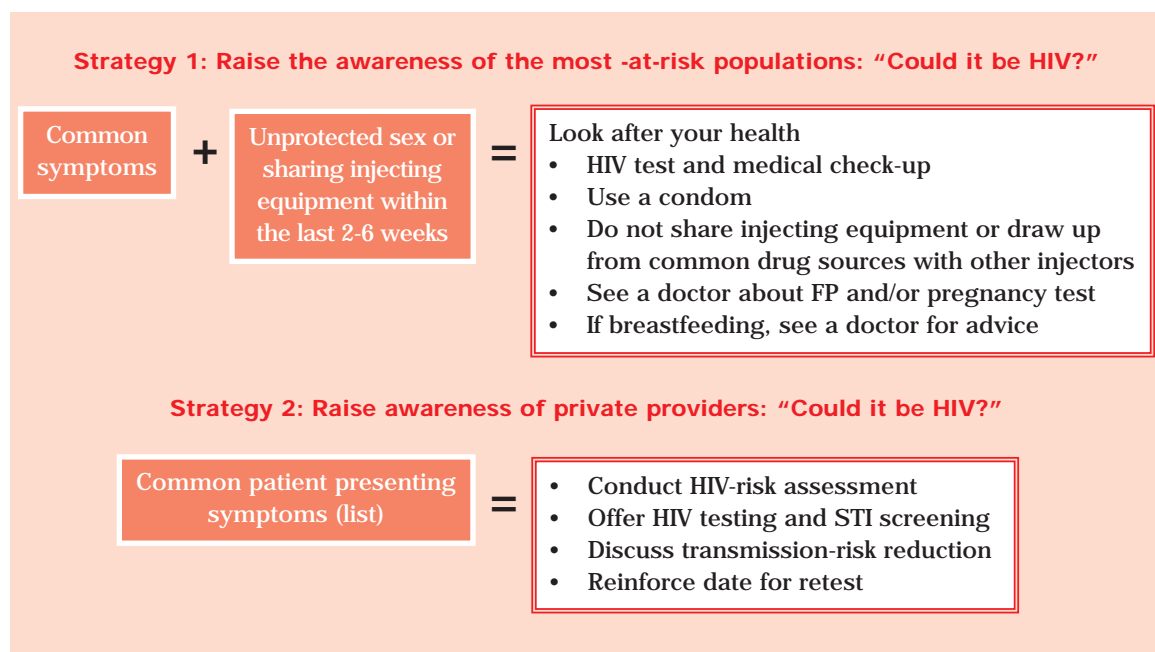
Meanwhile, we urgently need to address the following:

- Consent for what? (“health check”)
- Minors – authority to consent (test and treat)
- Coercive testing = low health-seeking behaviour, e.g. SWs avoid specific services and self-treat STIs; IDUs avoid rehabilitation that requires testing
- Lack of same-day test results – poor MARP rate of return for results; no money, no confirmed test, no result, no treatment; three tier test (different methods and different antigen targets)
- Negative results poorly given, no window period assessed (early infection as 50 per cent of new cases)

Poor practice and acute infection-related transmission could stem from poor risk assessment (time-related) and negative result provision (data collection vs. clinical recording). Most MARPs test in the window period; transmission may be up to 20 times higher during acute HIV infection, may account for >50 per cent of new infections; and MARPs have a multiple transmission opportunity to transmit during this period (Sources: Wawer, et. al, 2005; Remein, 2006; Sudarshi, et. al., 2008).

Strategies are needed to raise HIV awareness among MARPs and private providers as follows.

Figure 8: Strategies for Raising Awareness of HIV



Barriers to HIV counselling and testing uptake include

- Third-party disclosure without client consent: Many countries do not follow UN guidelines. Greater efforts are required to support clients in disclosure, e.g. FHI SOP “five-item menu for disclosure.”
- Blood-bank safety at risk: MARPs access blood service testing because of the lack of affordable VCT and PITC, and blood service testing is free. However, there are no follow-ups and often insufficient assessment of risks.
- Screening of donated blood and related blood products that ensure safety of blood supplies: A single highly sensitive test may be considered as cost-effective blood screening. However, results should **not** be provided to donors, and donors assessed to be at risk for HIV should be referred to a VCT service.

To improve uptake of testing and counselling, there is a need to:

- Market VCT;
- Conduct “bottom-up” promotion (rather than “top-down”), including innovations such as outreach testing buddies, vouchers and packaged services, participation of targeted populations and addressing their needs and fears, and having a budget for promotion;
- Offer a minimum package of services that tips the balance between the pros and cons of testing; MARPs and competing health priorities (primary health services, well-linked or “brokered” on-site services), and include multi-sectoral support, e.g. income generation;
- Significantly scale-up free or very low-cost access to quality same-day testing (includes confirmatory testing) and effective EQA systems;
- Mix community, government and health institutions’ dedicated HIV budget funding for community testing and counselling or sponsorship of shared staffing and health regulations to allow NGO and mobile testing and address signage issues;
- Expand public-private partnerships such as brokering services or funded-counsellor placements in private providers; and

- Improve location of testing and counselling by ensuring easy access to VCT services.

Individuals are reluctant to attend services that are clearly signed as “AIDS Testing.” MARPs are frequently reluctant to attend services located at CDCs/government services. They seek testing with private providers. Also, there is still a reluctance to have non-health sector personnel offer services within government health clinics and hospitals. In a few settings, though, we have been successful in deploying NGO and government counsellors in private medical practices that offer pre- and post-counselling or pre-test information sessions.

To scale up testing and counselling, creative approaches for Group Pre-test information provision are required. In some settings, community volunteers and peer educators have provided pre-test group information sessions, computer-based risk assessment and pre-test information, and targeted video/DVD pre-recorded information with a trained group facilitator. There is a need to fund adequately the training and support of volunteer counsellors from affected populations and invest in counsellor training. T&C counsellors should be prepared to deliver OI and ART adherence counselling, positive prevention counselling and partner disclosure support counselling.

There is now a new UN Asia-Pacific HIV counsellor. VCT counsellors have assisted in other health services such as TB, STI adherence support and health promotion; RH counselling; maternal-child health counselling; support for chronic non-communicable diseases and conditions; and outbreak support and contact tracing counsellors, e.g. for avian influenza. Resource materials have been developed, namely: The HIV Counsellors Handbook: A Comprehensive Guide for VCT, PITC and Care Counselling; a 28 item toolkit; a trainers’ manual with step-by-step interactive training-session plans and the FHI QA QI Facility Assessment Guide.



Knowing your status, plan our future: Youth prevention in Papua New Guinea

Dr. David Passirem, Manager, Community Care and Counselling Support Manager, National AIDS Council Secretariat, Papua New Guinea

Dr. Passirem provided a background of the HIV & AIDS situation in Papua New Guinea and discussed the national response, including partnership and networking, some challenges and ways forward.

Papua New Guinea is a large island nation, situated north of Australia and sharing a land boarder with Indonesian Papua Province. With more than one thousand tribes and 860 plus languages spoken, giving HIV & AIDS messages and information to the entire population (6.3 million) using the one language or method of advocacy does not work. Advocating for HIV and AIDS in a society that has a high percentage of illiteracy and a large mobile population is another challenge,

especially given that so many communities are remote and difficult to access.

The central government in Papua New Guinea established the National AIDS Council (NACS), which set up Provincial AIDS Committees (PACs) in all provincial headquarters. Papua New Guinea's National Strategic Plan 2006-2010 focuses on treatment, care and counselling support; prevention and education; epidemiology and surveillance; social and behavioural research; leadership partnership and coordination; family and community support; and monitoring and evaluation.

The following table shows the HIV & AIDS situation in Papua New Guinea:

Table 2: HIV & AIDS statistics in Papua New Guinea

		2003	2005	2007	Trend
People living with HIV/AIDS	Adult and Children	19,738	32,904	56,175	Rising
	Adults 15+	19,117	31,864	54,448	Rising
	Adults (15-49) rates (per cent)	0.64	1.02	1.61	Rising
	Women 15+	10,806	18,407	31,883	Rising
	Children (0-14)	621	1,040	1,727	Rising
New HIV infections	Adult and Children	5,227	8,531	1,4638	Rising
	Adults 15+	4,874	7,954	13,684	Rising
	Women 15+	2,819	4,666	8,174	Rising
	Children (0-14)	353	577	954	Rising
AIDS deaths	Adults and children	2,185	3,871	5,995	Rising
Orphans due to AIDS	Orphans (0-17) currently LWHA	1,549	2,704	3,730	Rising
ART treatment	Number of adults (15+) in need of ART	2,437	3,204	5,712	Rising
	Number of adults (15+) on ART	80	1,098	3,000	Rising
	Number of children (0-14) in need of ART	233	384	636	Rising

Among the challenges faced by Papua New Guinea are to:

- Collectively address the issues of HIV & AIDS with young people as derived from the commitments of many partners and stakeholders;
- Train many more counsellors and youth peer educators to attend to peers and clients coming in for counselling and testing as more VCCT sites are opened and PICT policy is enforced;
- Help youth and adolescents to consent to know their status;
- Understand the quality of Papua New Guinea’s partnerships with stakeholders and urge communities to come forth to build solidarity in the fight against HIV & AIDS; and
- Mobilize community resources and strengthen networking.

To keep Papua New Guinea moving forward, the following actions should be taken:

- Conduct partner forums/meetings to share experiences from within the country and abroad;
- Develop innovative local response programmes;
- Identify and use local resources;
- Conduct participatory planning, outsourcing and capacity building for partners and stakeholders at all levels;
- Strengthen national coordination;
- Increase the number of programme partners and stakeholders to improve the means of data collection; and
- Create more focussed programmes to address common issues for a coordinated response.



Preventing HIV among young men in Viet Nam: Affecting gender norms and risk practice

Lisa Sherburne, Senior Specialist, HIV and Youth Health Save the Children USA

Ms. Sherburne discussed the rationale, approach, implementation activities and lessons learned from a prevention project involving young men in Viet Nam. She defined young people as aged 10-14; adolescents aged 10-19; and youth as aged 15-24 years. By these definitions, young people make up the largest demographic in Viet Nam. The average age of first sex is 20, and drug use is prevalent among 18-20 year olds. The HIV rate is highest (62 per cent of HIV cases) in 20-29 year olds.

Rationale of the prevention project:

- Young people are critical to HIV prevention, but not all young people are at equal risk, as shown below.
- Need for gender-based programming. More men (70 per cent) than women are infected. Highest risk behaviours are among young urban men – they have more sexual partners and riskier encounters and are more likely to inject drugs. The only HIV risk most women face is their husband’s behaviour.

Table 3: Risk Levels of HIV Infection

<p>Low: Mainstream young people</p>	<p>Medium: Vulnerable young people: migrants, factory workers, and those without parental supervision</p>	<p>High: Most-at-risk young people: street-based, incarcerated IDUs, sex workers and/or located in abuse ‘hot spots’</p>
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The sexual and drug-taking behaviours of young men are driving the HIV epidemic in Viet Nam (UNAIDS UNGASS Report, 2005-2010). There is growing evidence that HIV/ STI and violence risk is linked to early socialization that promotes certain gender roles as the norm (Pulerwitz, 2006). In Viet Nam, attitudes toward gender norms are associated with HIV-risk behaviours (Vu Manh Loi, 2008). Some gender norms in Viet Nam include:

- **For men:** Being sexually experienced, having multiple sexual partners, taking risks and drinking heavily with friends/ colleagues; and
- **For women:** Maintaining virginity until marriage, being submissive, keeping the husband satisfied and tolerating violence for the sake of family.

In-School Component: Vocational School Students

There are 350,000 students enrolled in the vocational school system of the Ministry of Labour. Most schools (and future workplaces) are in or near urban areas. The majority of young men 15-24 years old are away from home. Young people have varying levels of literacy and educational background. Some baseline practices of young men are that 30 per cent have had sex, 24 per cent with SWs, 55 per cent of first-time sex was unprotected, and 58 per cent of first-time sex took place when they were drunk. At their critical life stage, however, there is opportunity to

reduce current risk and establish life-long preventive practices.

Out-of-School Component: Street-based

There are 16,000+ young people (11,000 in Ho Chi Minh City) belonging to different street-based groups and are considered most-at-risk. The lack of 'papers' limits their ability to rent rooms, find stable jobs, or access services. Assessment findings reveal that some sell sex or have sex with SW, most sex is unprotected and there is high rate of injecting drug use.

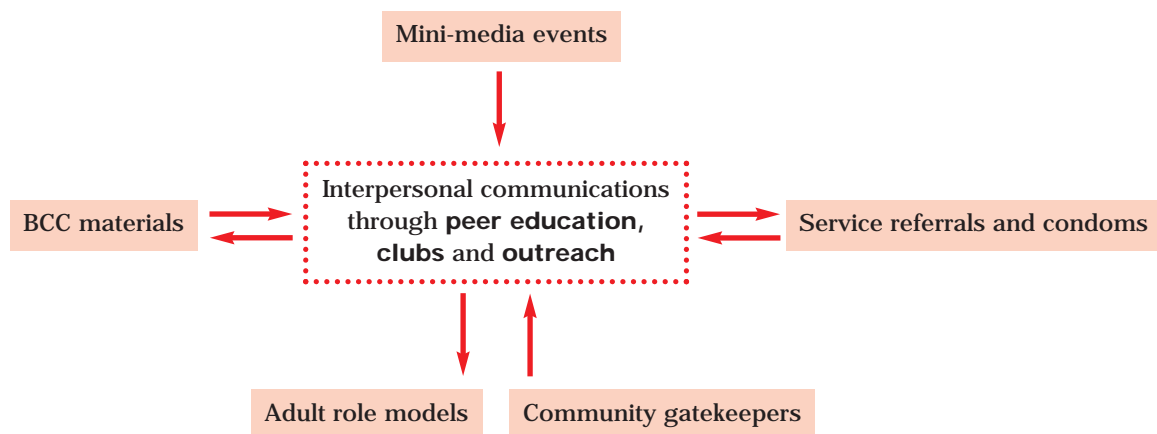
A project focused on primary prevention of HIV among young people in Viet Nam aimed to:

- Improve adoption of risk-avoidance/ risk-reduction practices among young men in Viet Nam;
- Improve knowledge, attitudes and skills related to HIV-prevention and gender;
- Improve availability and accessibility to quality HIV-prevention information and services; and
- Improve community support for healthy practices of young men.

The project adapts the proven risk-reduction curriculum from Brazil – Program H. Topics include men and their health, HIV & AIDS, love and relationships, substance use and violence.

The following shows the project's implementation activities:

Figure 9: Primary prevention of HIV among young people: Project implementation activities



Peer education clubs include 10 clubs in five vocational schools (three master trainers/schools) and four peer educators' (PEs') clubs that conduct weekly sessions with young men (25 per club), as well as street-based clubs in two cities with 30 street youth trained as PEs.

Interpersonal communication outreach includes vocational schools with peer educators and club members reaching out to friends and peers, with more than 15,000 condoms distributed, and referrals provided for additional services.

Mini-media events are held in vocational schools, wherein young people lead a series of fun and substantive events including games, contests and performances by young people that engage students, teachers and school leaders. There have been changing perceptions of HIV and acceptance of prevention and PLHIV.

Male role models are adults who train and support peer educators and have new knowledge, attitudes and skills, who serve as positive male role models for young men, and who provide counselling and guidance.

The mid-term survey in June (2008) measured any changes resulting from the project. Indicators being measured include behaviour change, such as the percentage of sexually active young men who report practicing a method of safer sex (abstinence, partner reduction, consistent condom use) in the past three months. Indicators also include

improvements in knowledge, attitudes and skills (per cent of young men who are more gender equitable); in availability of and accessibility to information and services (number of youth reached with IPC, number of referrals and number of condoms distributed) and in community support (number of schools/communities that incorporate HIV prevention in plans).

The following are the next steps and lessons learned:

- Expanding to additional schools - will reach more than 30,000 young men by September
- Assessments on the highest risk sub-groups (MSM; IDUs) on-going, with findings used to refine activities
- In response to demand from young women, pilot clubs will begin this year.
- Young men prefer the gender-based approach for HIV-prevention, including learning about their own bodies, health, and relationships, and having a safe space to learn and share.
- In-school component: sustainable model, while Out-of-school component model being tested

Ms. Sherburne concluded that gender is an important consideration in primary HIV prevention as gender-based programming helps to focus efforts and address risk behaviours, and there exist models for gender-based programming in the Asian context.



Youth Net
Natthapong Suksiri, Project Coordinator, Thai Youth Network on HIV/AIDS, Thailand

Mr. Suksiri explained that the goals of the Thai Youth Network (Youth Net) are for children and youth to learn and understand HIV & AIDS and sexuality. This includes access to services and the right to make their own decisions on having safe and responsible sex. Its purpose is also to “strengthen the capacity of youth networks on HIV/AIDS through sharing of

lessons learned on sexual health from each youth group.”

Youth Net’s strategies include:

- Recruiting new youth leaders and developing youth leaders to be informative HIV/AIDS facilitators;

- Establishing new youth groups and linking them with HIV & AIDS and other youth development networks;
- Encouraging the sharing of information and lessons learned; and
- Developing learning processes on HIV & AIDS and sexuality among youth groups across Thailand.

Mr. Suksiri shared Youth Net's work plans:

1. Promote access to health services by developing and promoting health services for youth including youth-friendly services, and capacity building of youth groups to be resource centres on HIV & AIDS and sexual health in their communities.
2. Raise community awareness by synthesizing knowledge and experience of youth groups to promote understanding and acceptance among adults; developing mass communication plans and strategies to promote public understanding of youth sexuality; and promoting understanding and non-judgmental attitudes towards HIV &

AIDS, condoms, gender, sexual health as well as sexual rights at all levels from community to national levels.

3. Build capacity of youth groups and networks by developing skills, concepts and work processes; providing technical support to youth leaders; supporting teams and partner organisations; promoting the participation of youth groups and networks in implementing activities; sharing information and advocating for youth policies; encouraging development of mechanisms for the sharing of youth group's experience; and strengthening HIV & AIDS networking at provincial and national levels through regular coordination with government, NGOs and other networks, including community health services, on public campaigns.

Youth Net encourages curriculum development of sex education, HIV & AIDS and youth rights, and the promotion of participation of youth in advocacy on health policy at all levels.

Discussions

- On issues related to the testing of minors and street children: FHI representatives noted that there are well-intentioned policies on testing in the region that prohibit testing minors involuntarily, but the definition of minors varies around the region, and often the policies are at odds with established laws. Policy mismatch and confusion surround testing. Some countries prohibit testing of minors, but the majority at 18 years have the right to decide on testing. For some countries, there is a question on whether we should follow internationally acceptable policies or the country's own laws. The best interest of the child should be the primary concern. If a child is ill and in need of health services, then it is within the child's right to avail her/himself of testing.

Most street children are in a different situation, which poses a very serious problem across the region. Some care service providers take personal risks and make decisions to test children. In some countries, there are mandatory policies related to sexual assault. It becomes a problem for service providers because they are required to report the case. There needs to be well-trained counsellors who can deal with street children in this context.

There is a need for better coordination of health policy and child protection policy. Policy must be in line with legislation. On testing of street children, often 'yes' is said because these children feel they have no choice. Counsellors should have a conceptual understanding of what is being talked about and the nature of the test and knowledge of a child's mental ability to undergo the test. There is a need for counselling prior to conducting tests. The best strategy is to scale up access to 'no or low' cost HIV testing and to scale up community-based services that are sensitive to the needs of people.

- On safeguarding blood supply: One of the most effective ways of reducing risk in blood donation is to have a good and accurate donor-risk assessment. Further, it is better to use rapid tests that post a high number of positive results. Not enough questions, however, are being asked of donors. Shortcuts are being taken, and that is putting the blood supply at risk.
- On school-based curriculum for MSM: While there are school-based programmes on sexual diversity, there are no outreach programmes encouraging tolerance of MSM among street children because they tend to be accepting of different practices. Some ministries are willing to incorporate topics on MSM openly.
- On condoms: Different types and sizes of condoms are available. Lots of strategies can be used to address condoms and their distribution. We need peer-educators to talk about the use of condoms to help maintain stimulation and encourage ejaculation and to acknowledge and talk about sexual dysfunction. Sometimes health workers are very hesitant to talk about sexual issues.

Session 6. Prevent mother-to-child transmission and paediatric treatment



Optimising PMTCT through linked response
Wing-Sie Cheng, Regional HIV and AIDS Adviser, UNICEF East Asia and Pacific Regional Office

At a third consultation in Guilin, China, in May 2007, WHO Western Pacific Regional Office, UNICEF EAPRO and UNFPA Asia and the Pacific Division, together with representatives from six countries (Cambodia, China, India, Indonesia, Thailand and Viet Nam), came up with a regional framework to operationalize linkages, combining multiple agendas with a set of common goals including:

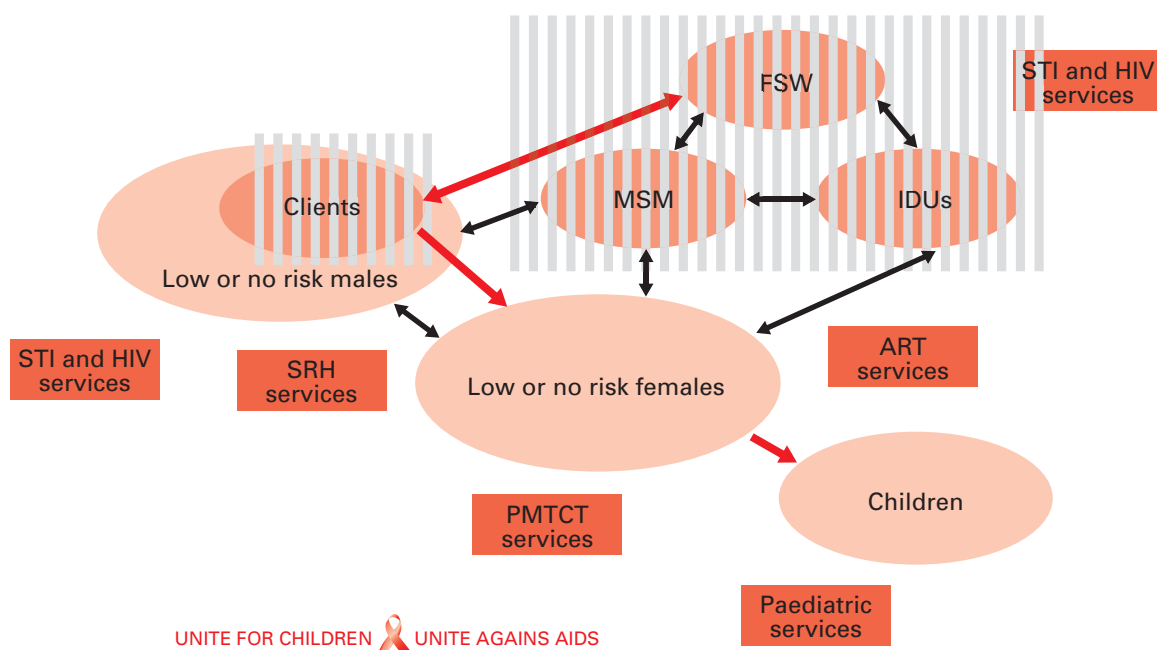
1. To reduce missed opportunities;
2. To increase the potential reach of clients;
3. To increase coverage within the health system itself; and
4. To improve cost-effectiveness.

This regional framework is an effort to link disparate services within the health sector to achieve common goals. It dates back to the

first consultation, a joint conference in Malaysia in November 2006, where seven regional offices within the UN came together to try to reach a common agreement about how to work together. Dr. Wendy Holmes of the Burnet Institute provided the theoretical underpinnings and rationale for health system integration, a concept that has been in existence for a long time. The question is how to implement it.

In low and concentrated epidemics, there is a need to examine the patterns of transmissions to maximize opportunities for response. It will provide keys on how to bring all the services together. The HIV & AIDS epidemic is feminizing in Asia.

Figure 10: How does HIV spread in Asia?



The four prongs of prevention of mother-to-child transmission (PMTCT) provide a matrix around which a comprehensive response can be built. The four prongs are:

- Prevention of HIV among women and mothers,
- Prevention of unwanted pregnancies among HIV-positive women,
- Prevention of HIV in newborns and children, and
- ARV treatment care and support.

These provide the most viable solution to protecting children. Protecting women will protect children. To protect women, their partners have to be protected.

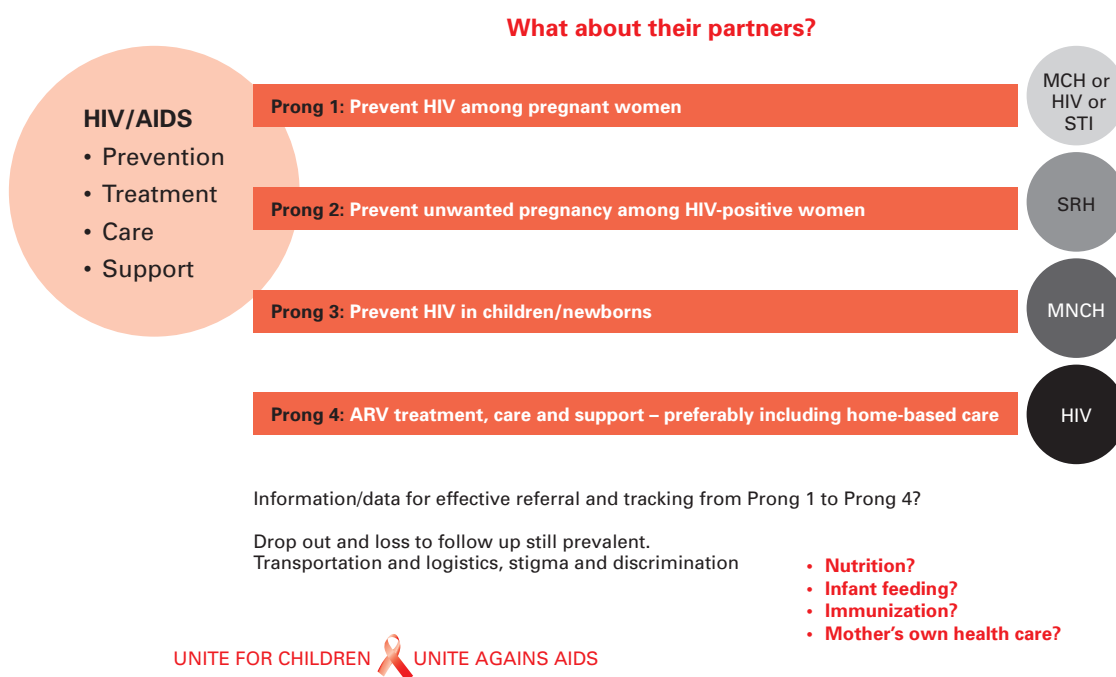
PMTCT efforts have been too focused on the third prong. Addressing all four prongs can foster linkages with other services within the health system for a comprehensive response. These linkages must be driven by information and data that are shared in the continuum for referral and tracking. Focusing solely on the prevention of HIV in newborns and children can have negative effects. Without stigma and discrimination being addressed,

women who test positive are reluctant to come back for PMTCT services, and then the children are not found. The investment in this intervention is then lost.

The proposed framework for a linked response aims to provide guidance and facilitate countries to:

1. Strengthen RH, ARH, family planning and PMTCT services, as well as mother, newborn and child health (MNCH) services, by pursuing joint activities with RTI/STI/HIV/AIDS services, including strategies involving accessing new funding opportunities;
2. Strengthen comprehensive prevention of HIV (including PMTCT) and RTI/STI by using multiple health services, including RH, ARH, MNCH and family planning services, and increasing community participation;
3. Increase access to HIV and STI testing and counselling for women, men and MARPs by using multiple health services, including RH, ARH, MNCH and family planning services; and
4. Increase the quality of RH, ARH, MNCH and family planning services to HIV-positive clients.

Figure 11: Need for linkage with PMTCT management



The framework provides a “win-win” benefit. Its linkages are both ‘vertical’ in going from primary health care to specialist services and ‘horizontal’ in going between HIV/STI and RH, MNCH programmes. To increase these linkages, methods include improving horizontal referrals between programmes and vertical referrals from village to townships, districts/counties, provinces and central, staff cross-over/staff cross-training and full integration. There is a need to maintain the continuum of data/information of adults and children living with HIV & AIDS across programmes, which is vital to achieving effective outcomes. For operational linkages to maximize reach and access, it is necessary to improve data/information management and joint accountability of results.

PMTCT doesn’t stop at delivery. It includes primary prevention, positive prevention, and prevention of transmission to children. Services should ensure HIV-free outcomes (e.g. deliveries are made but newborns are not brought back for test to ascertain status), child and maternal survival, and the prevention of child’s death from diarrhoea, dehydration, ARI and other diseases. Linkages should aim to improve health outcomes.

Citing the new WHO recommendations, Ms. Cheng said that the most appropriate infant feeding option for an HIV-infected mother should continue to depend on her individual circumstances, including her health status and the local situation, but should take greater consideration of the health services available and the counselling and support she is likely to receive. Exclusive breastfeeding is recommended for HIV-infected women for the first six months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time.

MNCH programmes play a key role. Governments and other stakeholders should revitalize breastfeeding protection, promotion

and support in the general population. They should also actively support HIV-infected mothers who choose to exclusively breastfeed, and take measures to make replacement feeding safer for HIV-infected women who choose that option. National programmes should provide all HIV-exposed infants and their mothers with a full package of child survival and reproductive health interventions with effective linkages to HIV prevention, treatment and care services.

Prioritizing HIV-infected pregnant women with CD4 counts <200

- About 12-15 per cent of all HIV-infected pregnant women have CD4 counts less than 200
- Account for 40-50 per cent of all mother-to-child transmissions
- Account for ~50 per cent non-obstetric maternal deaths
- Children of these mothers have a 3-4 fold increased risk of death

Replacement feeding in PMTCT sites

Samples of milk collected from bottles (n=94) being offered to infants brought by mothers to PMTCT clinic follow-up visits show that 63 per cent are heavily contaminated with E.coli and 28 per cent diluted (based on protein concentration). These, in spite of all mothers having completed 12 years of education, 72 per cent having fridges and all receiving good counselling on IFP.

Key issues for low and concentrated epidemics include: the need to clarify the denominators; questions of whether to test all pregnant women and to implement PITC in settings of high HIV prevalence, e.g. TB and STI clinics; joint accountability of results/outcomes, e.g. how many children are freed of HIV from ARV treatment during delivery; survival of HIV-positive mothers and HIV-positive children; inter-departmental coordination and engagement of civil society and communities; and linkage within the health system, and between health, education and social welfare systems.



Cambodia's experience: Linked response of relevant health families and community-based support to scale up comprehensive PMTCT and paediatric AIDS care

Dr. Mean Chhi Vun, Director, National Center for HIV/AIDS, Dermatology and STDs, Ministry of Health, Cambodia

Dr. Chhi Vun noted that the prevalence of HIV infection among 15-49 year olds and in ANC women in Cambodia has decreased from 1995 to 2006 and that the Asian Epidemic Model (AEM) has projected a similar decrease in the number of people aged 15+ living with HIV/AIDS in Cambodia from 2006 to 2012.

As to the rationale of linked response, Dr. Chhi Vun said that there have been missed opportunities to provide information and refer patients to relevant health services for appropriate testing or treatment. Other issues that need to be addressed include poor communication between health care providers and the community-based support teams, non-availability of all health service deliveries at the same health facility, and limited access to some health facilities due to geographic and resource constraints.

A linked response aims to help strengthen Cambodia's health care system; strengthen the existing reproductive health services; increase access to HIV prevention, testing, care and treatment including PMTCT services; and change the approach from clinical management to public health. It targets children infected and affected by HIV & AIDS. It seeks to protect children from HIV infection by providing comprehensive PMTCT to newborns, safe injection and blood safety to infants, and promoting condom use for adolescents, as well as increasing the access to medical care and treatment for HIV-infected children; increasing HIV testing coverage for the exposed children including rapid diagnosis for exposed babies; and scaling up paediatric AIDS care services and coverage.

By linking responses to relevant health service deliveries at health facilities and to community-

based support services, there should be an increase in the uptake of HIV testing and comprehensive PMTCT. There is a need to increase the number of referrals to HIV testing from other related health services in order to increase HIV testing coverage, to encourage health providers to initiate HIV testing (HPITC) and to ensure availability of HIV testing for potential HIV-risk groups (TB patients, STD patients, pregnant women, etc.).

There have been significant increases in number of women receiving HIV testing and counselling in ANC from 2002 to 2006. First ANC visit has risen from 9,239 to 48,010 (or from 12.1 per cent to 69.3 per cent); HIV tested from 1,116 to 33,251; and post-test counselling from 926 to 29,677. As of December 2007, 81 per cent received ART out of the estimated number of adults and children in need of it.

To increase access to comprehensive PMTCT services, NCMCH and NCHADS in collaboration with all partners need to: avoid duplications and gaps for logistic supply and capacity building through a joint statement addressing the role and responsibility of each NP; improve collaboration to support linking CoC/RH/MNH services at all levels; strengthen referral and follow-up linkages between FBC and community-based support, including PLHIV self support group; mobilize resources for securing financial support and focus on target populations (HIV PW, Partners of HIV male, spouse of the MARP and EEWs).

Some examples of rapid scale up of the uptake of comprehensive PMTCT services in poor resource provinces include the MoH endorsement in February 2008 of SOP for implementing the Linked Response for PMTCT (available at www.nchads.org), the implementation of

linked response in four ODs in Prey Veng and one OD in Takeo Province, and a situation analysis of Prey Veng Province. A rapid scale up of the comprehensive PMTCT services in poor resource provinces started in February 2008 in Zone 1 (4 ODs) with a population of 550,000 (~ 2700 P W, ~ 30 HIV Mothers). It targets all women on ART (245) and OI (165) [7 to 10 per cent of pregnant women], all spouses of HIV-positive men, and all women at high risk (EEWs, spouse often travelling, etc.). Results show increases in HIV testing centres from 5 to 9 sites, and in ARV Prophylaxis and exposed-infant follow-up, including rapid diagnosis (DNA PCR) from 1 to 9 sites. Thirty-eight health centres referred pregnant women or sent blood samples to HIV testing centres. HPITC is being implemented in all 4 RHs and 47 HCs.

The following actions are necessary to start linked responses at the district level:

- Assessment through situation analysis, resource availability, gaps and needs



Scaling up paediatric HIV care and treatment

Dr. Erik Fleischman, Senior Clinical Advisor, Clinton Foundation HIV/AIDS Initiative, Thailand

Dr. Fleischman said that there were more than two million children infected in 2004, 1,400 needless deaths daily, and only 10,000 children were on treatment outside of Brazil and Thailand. There has been an increasing access gap among children relative to adults.

Barriers to treatment include the following:

1. Paediatric formulations are expensive; adult pill splitting is not recommended.
2. Doses vary by weight and size, and the youngest children need special formulations.
3. Major HR constraints exist, and many health professionals believe only paediatricians can treat children.
4. Counselling children is complicated, and ensuring adherence is difficult.
5. Although children receive health care and testing, treatment for paediatric HIV children is not widely available.

- Selection of satellite and sub-satellite sites
- Revision, update and development of monitoring tools: register, recording and reporting template
- Revision, update and modification of the training materials: curriculum and other training tools
- Training: ANC staff (satellite and sub-satellite sites: six days; nurses [HIV testing]: three days)
- Orientation workshop for HC Chief and ANC staff (midwife or female nurse): one to two days; ANC staff, HBC team leaders and nurses (HIV testing): two days; and OD Management Team, PAO, MCH coordinators, NGOs and Head of HBC: one day

Challenges to linked responses include the increase in work load of existing health staff at HC and RH, conflicts of interest and competition for resources, lack of political will (NCHADS – NCMCH) and poor leadership and management of the OD Management Team.

6. Once identified, children often continue to be lost in follow-up.

In April 2005, President Clinton launched the Paediatric Initiative to address some of these.

Each country is presented with different challenges, so the Clinton HIV/AIDS Initiative (CHAI) works with its partner governments to identify and address their individual treatment barriers.

Over the years, CHAI has made ART affordable as shown by a significant price reduction of 89 per cent in paediatric formulations, from \$567 in 2004 to \$60 in 2006. It has improved drug formulations from individual syrups (5 to 10 ml of each of three syrups, twice per day) to fixed dose combination tablets (1 pill, twice per day). It also has increased access to early

infant diagnosis, increased confidence of health care workers, and expanded and extended paediatric HIV testing and care.

CHAI's next priority is to improve quality and reduce loss to follow-up. The challenges include the lack of testing, children not returning for test results, incorrect or lack of clinical staging and progress of disease remains unchecked, and poor adherence.

Dr. Fleischman notes that CHAI will give priority to PMTCT. So far, a new initiative on PMTCT was started in 2008 in a few partner countries. In collaboration with partner governments, CHAI is seeking to reach as many women as possible in targeted geographic areas and to implement the highest standard of care possible, including the minimum of 2006 WHO Guidelines for PMTCT, e.g. pregnant women who require HAART due to their clinical condition will receive it, and for those that do not yet require treatment, they will receive AZT starting at 28 weeks and sd-NVP and 3TC at onset of labour plus a seven day tail; replacement feeding and/or counselling to breastfeed only; and Early Infant Diagnosis (DNA PCR with Dried Blood Spot). The use of community health workers, traditional birth attendants, lay workers and/or PLHIV mentors will be an integral component of these programmes.

CHAI began purchasing paediatric medicines through UNITAID in November 2006, and in collaboration with government and other partners, nearly 70,000 additional children have been reached. However, this is still not enough.

CHAI also has carried out the following in the past years:

- Supported the construction of a number of paediatric wards in Cambodia; contributed to paediatric guidelines and training curricula; provided support for a Logistics Management Unit and Laboratory; donated commodities and provided ongoing technical assistance (TA) for EID; partnered with NCHADS to implement Linked Response for PMTCT in Prey Veng
- Supported a national treatment programme since 2005 to start and scale up paediatric treatment in China with technical and programme support, clinical training and mentoring, and donation of paediatric ARVs; supported a national programme to roll-out second line ART; focused partnerships in four provinces with highest burdens; launched EID through a national partnership in six provinces; addressed psycho-social issues for HIV-positive youth
- Commencing in 2008, assisted Indonesia MOH to initiate paediatric CST across the country; launched paediatric mentoring programme in Tanah Papua; provided support to central lab for CD4, EQA and EID; and provided TA for Supply Chain management
- Supported Papua New Guinea National Department of Health to increase testing in paediatric OPD's in major hospitals; sustained mentorship to national paediatricians at select sites; implemented case management systems to reduce loss to follow-up and to provide vital services such as transportation/nutritional support, DNA PCR training and implementation
- Strengthened paediatric treatment in ten provinces in Viet Nam; provided on-site clinical mentoring for doctors; supported VAAC in drug logistics management; provided direct laboratory TA for CD4 guidelines, strategy and sample transport network; and donated rapid tests and CD4 per cent kits



Paediatric HIV management towards greater survival of children living with HIV in Thailand

Dr. Rawiwan Hansudewechakul, Chief, Paediatrics Department, Chiang Rai Prachanukroa Hospital, Thailand

Dr. Hansudewechakul noted that since the initiation of Thailand's ART programme in 2003, more than 6,000 children have been treated at various hospitals. The system, however, is becoming increasingly overburdened as the number of patients is increasing.

Taking care of children on ART is complex. Families living in remote areas have difficulties bringing children to the hospital. Chiang Rai Prachanukroa Hospital has developed a comprehensive community-based ART programme that has been successfully implemented and is now being expanded in more than ten provinces. HIV prevalence peaked in 1999 and is now under 1 per cent in Chiang Rai. The vertical transmission rate was 42 per cent in 1990, but today it is 21 per cent with formula feeding and 4 per cent with the PMTCT programme.

From 2002 to 2005, in conjunction with a local NGO the AIDS Access Foundation, the hospital began its community-based ART programme. It entails five steps to providing complete HIV care to children. Health workers and parents work as a team. The five steps are:

1. Preparation: two to three visits at the hospital
2. One-day preparation meeting, home visit
3. Starting ART date
4. Home visit on day three, hospital visit on day 14 to monitor progress and adherence
5. Long-term follow up with monitoring visits every month for the first six months, and every two months after that

Families are given a booklet in which they write when and how many pills they give their children. The pill dispenser and booklet are checked for adherence. Families attend day

care activities to receive ART and promote adherence. Some receive home visits while sex education and self-esteem building activities are targeted to adolescents.

From 2005 to 2007, more than 300 health care providers were trained. Community hospitals are providing the same quality as total care hospitals, and 97 per cent of children in care remain clinically stable. Monitoring visits are made to community hospitals two to four months after training to observe health care workers' competence in HIV care.

From 2002 to 2007, a total of 428 cases were on ART (with 42 reported deaths). The number of cases on ART had increased from 2002 to 2007. Chiang Rai developed a comprehensive paediatric HIV care programme that expanded the ARV adherence program to 16 community hospitals in 2005-2006, two hospitals (in Udorn and Ubon) in 2006, six provinces in 2007, and another six provinces will be covered in 2008. Trainings were conducted (including one on day care), which involved team meetings and observations. A four-day training activity was conducted for the provincial hospital team. A total of 16 teams were trained and 171 patients moved. During a community hospital visit, a meeting to discuss update on ART was held.

At the provincial level, the HIV QUAL is being implemented through the Children ART Network (CAN), which was established in eight hospitals in 2007 and will be introduced in 14 more in 2008. Special indicators at CAN sites include the percentage of ART cases with viral load < 50 copies/ml after one year of treatment and the percentage of ART cases who still are on first line regimen after five years of ART.

Discussions

On routine offer of testing in health clinics: In most countries, the only way to identify infected children is through infected parents, but identification is not being done as well as it could be. Other ways could be through screening at maternal and child health clinics. Immunization clinics were chosen because they have the largest numbers of children. We may need to start with sick children.

Consolidated group outputs: “How to link four Ps around local epidemics”

Participants were divided into eight working groups. The purpose of the session was to provide delegates with an opportunity to discuss progress on the scaling up of the “4Ps” and to develop ideas on how to ensure better linkages between all components. Each small group was asked to brainstorm the following questions:

- What have been the achievements in scaling up the “4Ps” since the Hanoi Consultation?
- How can we better link the “4Ps”?
- What are the challenges for linking the “4Ps”? What measures will you take to overcome the identified challenges?

On achievements to scaling up the 4Ps since the Hanoi Consultation:

Cambodia: Created a national multi-sectoral OVC taskforce; conducted a national OVC assessment and mapping of responses to OVC; developed a package of essential services for children; and allocated US\$ 1.6 million budget per year for orphans and vulnerable children (though a huge funding gap remains). Cambodia has linked PMTCT into home-based care, with referrals to ANC. It had obtained funding for paediatric AIDS care from GFATM. There is good collaboration among stakeholders. Life skills and peer education are being implemented by the ministries of health and education through non-government organizations.

China: 2.65 million women were screened for HIV, of which 2,706 were found HIV positive. Of this number, 80.4 per cent are on ARV. Of 8,000 HIV-positive children in high-risk zones, 800 are on ARV. A policy is in place to protect OVC through welfare programmes. By the end of 2007, 271 counties had implemented PMTCT, reaching 2.64 million pregnant women with VCT. China has integrated PMTCT into general ANC. By the end of 2008, China plans to scale up further by targeting 333 counties and by developing national guidelines and training modules as well as using the existing MCH system to implement PMTCT. A remaining challenge is determining how to scale up in more areas (2,800 counties in the country, some of which do not have any HIV-positive woman detected so far).

Indonesia: In 2005, 798 pregnant women were tested for HIV, and, in 2007, 4,830 pregnant women were tested for HIV; in 2007, 89 HIV-positive pregnant women received PMTCT prophylaxis. PITC was newly introduced. Indonesia established a national PMTCT taskforce and developed a communication strategy. Also, it has been strengthening the evidence base across all 4Ps. The support and commitment of political leadership is strong, with policies and guidelines in place.

Lao PDR: Provided single dose NVP based on WHO guidelines (AZT regimes); created a PMTCT taskforce; developed PMTCT guidelines, integrated reproductive health and HIV & AIDS into the school curriculum up to the university level; included life-skills education in the curriculum of 100 per cent of the colleges for teachers; implemented life skills in 11 provinces; and provided non-formal education to out-of-school youth.

Malaysia: 100 per cent coverage of PMTCT and paediatric AIDS care (of known cases); prevention among young people and protection through partnerships; and peer education in schools.

Myanmar: Supported 15,000 orphans and vulnerable children; PMTCT services made available in 106 townships and 37 hospitals; with 317 paediatric AIDS cases, paediatric AIDS care offered in 11 hospitals; integrated life-skills education in the school curriculum; and 7 NGOs implemented programmes for out-of-school youth.

Papua New Guinea: Progress on the 4Ps began in 2000 and accelerated in 2002; no statistics on orphans; strengthened capacity building, and mapping in progress.

Thailand: 95 per cent PMTCT and 100 per cent paediatric care coverage (of known cases), and HIV prevention among young people through partnerships.

Timor-Leste: Only two Ps (PMTCT and prevention) so far are being implemented. Timor-Leste has provided PMTCT services in one facility and made available ARV in two national facilities since 2007. Two HIV-positive pregnant women received PMTCT prophylaxis in 2007. Other achievements include provision of life-skills education to adolescents; collaboration among different stakeholders including the UN and NGOs; a national HIV campaign reaching 40,000 young people aged 15-24 years in 13 districts; and training 6 young people and 6 IDP youth as peer educators who, in turn, reached more than 17,000 young people.

Viet Nam: High Government's commitment to HIV response; developed NPA on children; established a PMTCT protocol in high-prevalence provinces; and good collaboration among partner groups regarding children and AIDS.

Clinton Foundation: Raised funds for PMTCT; increased technical assistance for PMTCT; provided large quantities of paediatric ARVs but limited lab assistance; and provided cotrimoxazole. Efforts have been mainly focused on treatment – not much has been done to address prevention.

Regional level: In terms of the ASEAN Secretariat after the Hanoi Consultation, a policy-level commitment among ASEAN members was evident with the incorporation of the Hanoi Call to Action into the ASEAN Declaration. The ASEAN Secretariat also developed a regional proposal focusing on PMTCT, since it views this as essential to reduce the number of new infections in children.

In sum, there have been noted increases in the levels of commitment of national authorities, collaboration among partners through partner groups on children and AIDS, and interest of donors in HIV response after the Hanoi Regional Consultation. Most countries have created task forces, developed guidelines and models, and established linkages, which include capacity building. Countries noted improvements in data collection, ANC surveillance, HIV-Q, VCT and partnerships. Child protection laws are in place, and some countries are now in the process of reviewing these. Needs assessments were also undertaken. Every country now implements paediatric ART, with some countries having moved from tertiary level to district level (thereby, drawing closer to the communities). ART is now less costly and more available. PMTCT has been linked with other programmes, such as MCH/RH. There is now growing emphasis on youth-focused prevention programmes, targeting street-based and school-based youth. Some countries have developed youth-friendly prevention services and youth-focused curriculum on life-skills and gender.

On better ways of linking the 4 Ps:

Linking 4 Ps into existing systems/structures/programmes

- Mainstream the 4 Ps into the agenda of different sectors to ensure that all Ps are linked into the already existing sectoral programmes.

- Link the 4 Ps into existing systems/national programmes, rather than each P with the others, e.g. in China, MCH since 2003, comprehensive HIV programme in 147 counties.
- Integrate 4 Ps within existing structures and non-HIV related programmes (i.e. FP, MCH, child protection); for alternative care policy, include children affected by HIV within the broader framework of 'Children in Need of Special Protection.'
- Create a Continuum of Care Coordination Committee at the district level (Cambodia and Viet Nam); in all levels, implement primary care in provincial and referral hospitals; identify referral needs and gaps.
- Remember the 'Three Ones' principle: one authority has the responsibility for all HIV response, including the 4 Ps.

Approaches and examples

- Multi-sectoral national and grassroots level coordination bodies, e.g. Cambodia AIDS Committee and Commune Councils/Committee of Women and Children that can develop National Strategic Plans and provide oversight and assign responsibilities to different ministries and other stakeholders as well as monitor their performance.
- Inter- and intra ministerial approaches (Health, Education, Labour, Social Welfare, Youth and Women)
- Formation of National Task Force on HIV, community networks, FBO (interfaith consultations in Lao PDR, Myanmar and Cambodia), and PLWHA networks (in China, Lao PDR, Philippines, Cambodia, Indonesia and Viet Nam)
- Strengthening of National Task Force (inter-ministerial) for policy and implementation to overcome obstacles; creation of technical working groups
- Positive promotion of HIV in policy frameworks/national level
- In low prevalence countries (Philippines), decentralization of services to the lowest level of governance
- Donor harmonisation – donors to work within government framework
- Case managers/PLWHA support to groups – establishing links between facility-based care and community and reducing loss to follow up
- Scaling up of linked responses and sharing good examples already existing in the region, i.e. continuum of care services, family-centred services/family-centred care model, one-stop shop for all services
- Ensuring a good baseline and involving stakeholders in baseline process
- Innovative documentation and effective dissemination (Asian research)
- Process-oriented life-skills programmes and Youth Forums (Cambodia, Philippines, Malaysia and Myanmar)
- Identification of all entry points for paediatric treatment and PMTCT; need to explore more (STIs, children of IDUs, etc)
- Implementation of gender-based programmes
- Accessing MARPS and making services more accessible to MARPS, by having more services available and including MARPS in policy and programme design and planning
- Implementation of home-based care
- Active involvement of PLHIV in identifying families for care and in addressing stigma at the community level

Commitment and support

- National commitment to de-stigmatization programmes is needed to reach MARPs; NPAs have laws on OVC paediatric care and prevention.
- More resources and capacity building provided for staff and caregivers

On challenges to linking 4 Ps:

Concept, framework and approaches

- The word “integration” is confusing and scary, as it implies changes in structures and responsibilities. It is better use “enhancing linkages,” “coordination,” or “harmonization.”
- Some countries do not have ‘Three Ones’ principle, i.e. having one programme as an overarching framework for all sectors.
- Mixed definitions of targeted populations, OVC, vulnerable, street children, etc.; there is a need for global agreement on definitions
- Data quality/collection/evaluation – lack of estimations and denominators and country-level definitions; monitoring also a challenge
- In some countries, global guidance on targeting (target broadly to capture targeted population) contradicts country/donor conditionalities, so there is a need for donor harmonization.

Resource constraints

- Direct funding for HIV programmes (only) limits integration of the 4 Ps within existing structures and programmes that are non-HIV related (i.e. FP, MCH, child protection). Situations that put children at higher risk of HIV infection indirectly (i.e. migrant, trafficked children) are often not covered by funds directly intended for HIV.
- Decentralization of services is problematic, e.g. funds for national programmes could not be used for activities at district level (Indonesia).
- Difficult to deploy health personnel in remote areas
- In many countries, no national programme funding is provided to NGOs or CBOs that are expected to implement activities.

Socio-cultural factors

- Cultural issues impact on what we can and cannot do, e.g. MSM/transgender people could not talk about their specific needs and practices at health services, as their situation is culturally sensitive and not acceptable in their culture.
- Stigma and discrimination

Coordination issues

- Different stakeholders in different sectors have responsibility for different Ps, which makes linkages difficult (vertical systems).
- Different ministries have their own issues to address and do not want to lose money, turf or power. Weak coordination between government/donors and partners
- Limited number of PLWHA support groups (NGOs, CBOs, FBOs), and lack of resources/capacity building exchanges

Day Three: 2 April 2008

Session 7. Partnership



Australia's contribution to HIV responses in the Asia-Pacific
Phillippe Allen, Minister-Counsellor, AusAID

Mr. Allen told the story of one of the first HIV cases in Australia and shared key responses to HIV and AIDS.

Over twenty years ago an Australian child, Eve Van Graft, was one of the first cases of HIV to draw the attention of the public. Eve had contracted HIV from a blood transfusion as a baby. At that time, Eve and her parents were victims of ignorance and discrimination. At the age of three, she was told to leave her pre-school or attend wearing a plastic mask.

The sympathy and outrage provoked by her case contributed to the development of Australian policy on HIV as well as anti-discrimination legislation and public education campaigns that ensure children with HIV in Australia today are free to attend schools, receive services and enjoy all the benefits and pleasures available to other children.

Cases like Eve's have made governments and health and education authorities all over the world aware of the need for what is now called 'an enabling environment': policy and laws that protect children and adults with HIV from discrimination, protect their privacy and keep their HIV status confidential, as well as providing education to dispel ignorance and promote behaviour change, along with access to services providing HIV prevention and care for people of all ages.

As a donor country, Australia has had an opportunity to share lessons learned from its own epidemic with its neighbours in the Asia Pacific region, as well as to provide funding for national HIV programmes of governments and civil society.

Following the national elections in Australia last year, the new government has reaffirmed a commitment to development aid with a renewed focus on basic health services and support for an effective response to HIV in the region. AusAID is in the process of reviewing its HIV strategy. According to Mr. Allen, forums (such as the current Regional Partnership) will contribute to Australia's understanding of the course of the epidemic and emerging issues in Asia and the Pacific and the importance of a coordinated, harmonized approach.

Within the Asia Pacific region, Australia's geographic focus is particularly on Papua New Guinea, the Pacific Island nations, Indonesia, Timor-Leste and the Mekong sub-region. It is not a case, however, of 'one size fits all'; the HIV situation varies widely from place to place and requires different responses.

In the Pacific region, where over 50 per cent of the population is under 25, AusAID has worked with its partners in government, church groups and non-government organizations to

target youth in prevention programmes. One of the most forward-thinking and comprehensive policies in the region has been the HIV/AIDS Policy for the National Education System of Papua New Guinea, adopted in 2005. This sector-wide policy covers four key areas:

- Prevention for students, with HIV & AIDS and life-skills education integrated into curriculum areas at all levels and complemented by peer education programmes;
- Care and support for infected and affected students through counselling and referral on a range of issues from sexual health, sexual assault, post-exposure prophylaxis and voluntary counselling and testing, to bereavement, positive living, treatment and care;
- HIV workplace policies covering all staff with occupational health and safety guidelines, education, counselling, treatment, confidentiality and anti-discrimination measures; and
- Management response to HIV, with structures in place to ensure that all provinces, districts and schools implement the policy and report on this annually.

While adoption of comprehensive strategies in the Pacific is a little less advanced than in Papua New Guinea, the Pacific Regional HIV and STI Strategy 2009 -2013 for all 22 Pacific Island Countries and Territories also promotes the inclusion of prevention education on HIV and other sexually transmitted infections in formal school curricula. In 2007, Ministries of Education in the Pacific endorsed the inclusion of HIV education in the school curriculum, and UNICEF is now taking the lead on this.

One of the achievements of AusAID's partners in the Pacific has been the focus on innovative and gender-sensitive communication for behaviour change. One example is the "Love Patrol" TV series, which, like the popular African soap "Soul City," promotes both behaviour change and gender equality.

In Asia, AusAID has provided ongoing support to Indonesia. Recently, the Government of

Indonesia approved support to a provincial Education Strategic Plan for Papua Province. This will involve UNICEF and AusAID, and discussions are currently underway to consider how this will be achieved.

AusAID is also active in the Mekong area with funding to government and non-government organizations in China, Viet Nam and Lao PDR. In the Philippines, where AusAID has provided funding to UNICEF for over a decade, \$1.34 million is dedicated to HIV prevention for disadvantaged youth.

In addition to supporting HIV prevention, AusAID is contributing to increased access to anti-retroviral treatment in the Asia Pacific region. In Papua New Guinea, there is a generalized AIDS epidemic, and numbers of affected women and children are increasing. Treatment and care are important components of the programme there.

As mentioned earlier, Australians were inspired by the resilience of children like Eve Van Grafhorst. Sadly, Eve died at the age of 11. At that time, life-saving anti-retroviral drugs were not yet available. Today, all children and adults in Australia and New Zealand who need anti-retroviral treatment can access it. Despite the great advances of medical science over the past 15 years, many children in the region today do not have access to these drugs. The Australian Government is now working with GFATM and the Clinton Foundation to improve children's access to paediatric AIDS care in Papua New Guinea, Indonesia, Viet Nam and China.

In Papua New Guinea, 150 children are now on paediatric formulations of anti-retrovirals, and the Clinton Foundation aims to ensure a continuous supply of paediatric formulations for up to 300 children. Malnourished children on treatment also have access to nutritional supplements.

The Clinton Foundation is supporting Indonesia in developing its national plan for a paediatric care and treatment programme, so that a sustainable response can be built.

In Viet Nam, 1,200 children will benefit from a Memorandum of Understanding between President Clinton and the Vietnamese Minister of Health for the donation of drugs and lab diagnostics equipment.

China's remote Xinjiang Region is heavily affected by the epidemic, which is rapidly spreading from injecting drug users into the general population. AusAID is supporting the Clinton Foundation to introduce early infant diagnosis, and by December 2007, 35 HIV-positive children were on treatment.

Donors need to invest in the greatest resource available to the region: our children and young people. We need to follow up on the Hanoi Call to Action, to maintain the commitment to prevention among our young people, particularly those who may be at a greater risk through drug use or sexual activity, without forgetting the need for treatment and care. We have to remember that although children – like Eve Van Grafhorst – have powerful messages for us, their voices are not always strong.

One of Australia's contributions to the regional response to HIV has been its commitment to leadership as a strategy to challenge stigma

and resist complacency. The attendance at forums like this by senior government officials, media, business and political leaders can be an important part of the effort to support children, youth, women and men who are living with HIV and to allow their voices to be heard.

Supporting the participation and leadership of HIV-positive people including women and youth living with HIV is vital to the success of our responses. AusAID, in partnership with UNAIDS, is funding the regional organization of people living with HIV, APN+. By involving positive people in our discussions and decisions, we ensure that our programmes are grounded in the realities of the epidemic. This is crucial to battling the stigma that undermines our programmes.

Mr. Allen concluded that AusAID is very pleased to be working on children's issues in close partnership with governments in Asia Pacific countries, with UNICEF, UNAIDS and its co-sponsors, and with the Clinton Foundation. But ultimately, according to him, it is our partnerships with the communities most affected by the epidemic that will be the most crucial to the success of our responses.



Inter-faith regional consultation on Children and HIV
Dr. Rabia Mathai, Senior Vice-President, Catholic Medical Mission Board

“Faith-based organizations are a vital part of civil society. Since they provide a substantial proportion of care in developing countries, often reaching vulnerable populations living under adverse conditions, FBOs must be recognized as essential contributors towards universal access efforts.” (Dr. Kevin De Cock, Director, Dept. of HIV/AIDS, World Health Organization)

Dr. Mathai provided highlights from the Interfaith Regional Consultation on Children and HIV, organized by UNICEF EAPRO and held from 15-17 January 2008 in Bangkok, Thailand.

The Consultation aimed to:

- Identify the relative strengths and weaknesses of FBOs in responding to HIV and addressing the needs of children affected by AIDS (CABAs) and of orphans and vulnerable children;
- Identify relevant activities that FBOs are conducting in East Asia and the Pacific; and
- Discuss and suggest strategies to facilitate and strengthen interfaith activities for effective care and protection of children (CABAs, OVCs, and young people).

The Interfaith Consultation revolved around four key themes:

1. Strengthening the capacity of families,
2. Community-based responses,
3. Accessing essential services, and
4. Having a supportive environment.

The methodologies used were presentations of best practices, lessons learned and evidences related to FBOs' HIV activities, group discussions (including country experiences) and informal information exchanges (including exhibitions).

A number of faith-based organizations gave presentations, and Dr. Mathai explained the objectives and key strategies/programmes of each organization:

- Novices Aids Intervention & Rehabilitation Network (NAIRN) aims to: develop novice monks as peer educators on HIV & AIDS and Narcotics Harm Reduction, and as spiritual leaders for youth; promote novice ordination as an alternative choice for youth; gain greater recognition of the important role that novice monks have to play in preventing and/or solving social problems, particularly those related to youth; and encourage youth to apply traditional and faith-based values when confronted with problems.
- Asian Interfaith Network on HIV/AIDS (AINA) is an organization composed of various faiths and religions in Asia that encourages and facilitates the involvement of faith and religious communities in a concerted and coordinated effort to help change the trajectory of the HIV & AIDS epidemic.
- AMAN (Asian Muslim Action Network) conducts workshops, consultations and networking and facilitates PLHIV networks.
- Vietnam Fatherland Front participates in the development of government laws and policies on HIV & AIDS prevention and control with the aim of promoting the role of religious organizations in addressing HIV & AIDS. It also encourages organizations and individuals participating in HIV & AIDS prevention and control and develops models of self-help groups for PLWAs. In addition, it mobilizes the participation of society and the finance and technical contributions from organizations and individuals on HIV & AIDS prevention and control.
- Hope Initiative, World Vision mobilizes faith communities and community care of orphans and vulnerable children through community-care coalitions. It is also involved with the prevention of HIV among children and youth. World Vision works with over 29,000 congregations in 22 countries. Over 4,100 congregations had formed congregational Hope action teams – 14 per cent of total congregations. In 2007, World Vision and partners trained 54,240 people, including 10,267 senior faith leaders, from 8,100 congregations. It is expanding its reach to other faith groups, including the Muslim adaptation of the CoH programme.
- ANGLICARE STOPAIDS in Papua New Guinea provides a number of services: VCCT; drop-in centre; counselling services; home-based care; STI service; VCCT and counselling training; home-based care training; peer-education training; condom education/demonstration and distribution; awareness and advocacy; adult literacy programme; and drama and multimedia presentations.
- Catholic Medical Mission Board (CMMB): The CMMB-SACBC-Bristol Myer Squibb Foundation Partnership: Choose to Care (Prevention, Care and Support) 2000-05 was deemed a UN Best Practice. This effort in five southern African countries fostered 144 sustainable community-based projects for OVC, prevention and home-based care. CMMB also supported the community mobilization intervention model for PMTCT and ART in Kampala, Uganda, and the 'Men Taking Action' programme in Zambia, which empowers men to become part of the HIV solution.

- Led by FHI, the Community Faith-Based Regional Initiative for Orphans and Other Vulnerable Children (FABRIC) implements child-focused, family-centred and community-based programmes. It encourages early diagnosis of HIV and integrates programmes within the continuum of HIV & AIDS management, emphasizes the provision of quality services and provides funding support for FBOs sub-granting, performance improvement, coordination and sustainability. It also undertakes training workshops for FBO staff, on-the-job technical support and guidance, exchange visits for organizational learning, facilitation of links for local FBOs with government and other local community-level structures, and support linkages to government and other stakeholders.
- Develop strategic information to enhance FBO effectiveness, particularly in developing a database of FBO initiatives, best practices, lessons learned, etc. and in facilitating situational analysis and strategic planning.
- Priority recommendations for Regional Interfaith Strategies include the establishment of a system for knowledge sharing among FBOs, development of clear guidelines on interfaith partnerships (considering equal representation of faith, participation, distribution of resources, etc) and the establishment of a monitoring and evaluation system, which includes evidence-based documentation reporting.

Dr. Mathai also cited the contributions of the following organizations in providing durable and sustainable ART and in AIDS-relief efforts: Catholic Relief Services, Institute of Human Virology, The Futures Group, Interchurch Medical Assistance and the Ecumenical Advocacy Alliance EAA Campaign for Paediatric ART. He also noted the Policy on Religious Response to the HIV/AIDS Epidemic in Cambodia, which was adopted in May 2002 by the Minister of Cults and Religions. The Policy aims to ensure that the religious sector fulfils its role in the response to the HIV/AIDS epidemic in Cambodia, through integrated religious community mobilization for effective multi-sectoral HIV/AIDS prevention, care and support.

Next, Dr. Mathai summarized the Consultation's participants explanations of the roles of faith-based organizations:

To **strengthen family capacity**, FBOs need to:

- Enhance their communication through the publication of an interfaith newsletter and the establishment of an interfaith website; build their capacities to facilitate training of trainers on communication and advocacy, monitoring and evaluation, gender issues/sensitivity, diplomacy, strategic planning, programme/project management, proposal development, community organization and development, resource mobilization and family values;

To **create/strengthen a supportive environment**, it is necessary to:

- Ensure that FBOs are recognized/mainstreamed into a national framework/strategy for planning, programming and policy on HIV & AIDS;
- Enable FBOs to play an important role in reducing stigma and discrimination against PLWHA;
- Mobilize resources from outside and within communities for HIV & AIDS responses;
- Facilitate participation of PLWHA and OVC in the planning, monitoring and development of HIV & AIDS policies and programmes; and
- Improve policies and legislative framework.

To **motivate FBOs**, it is important to:

- Promote the human face and dimension of HIV & AIDS and the humanitarian perspective;
- Enhance existing partnerships and create new partnerships with a range of stakeholders;
- Undertake networking and information sharing with other FBOs, government and other civil society organizations;
- Involve PLWHA with FBOs and their programmes;
- Use root causes of HIV as an entry point for mainstreaming HIV & AIDS; and
- Ensure accessible resources and support for FBOs.

Dr. Mathai cited the 2004 World Conference for Religions of Peace (WCRP) and UNICEF study on FBOs' response to the needs of orphans and vulnerable children. Of 651 FBOs, 467

have provided material support, 404 have provided school assistance, and 341 have provided prevention services. More local churches than denominational have been involved, and Christian NGOs have provided spiritual support and counselling and promoted abstinence. More denominational and Christian NGOs have provided material support, orphan

support, training, and advocacy or lobbying. Most NGOs implement prevention and care activities. More FBOs, however, have supported orphans and vulnerable children, compared with NGOs and community-based organizations. The study further reveals that FBOs have weak capacities in areas of administration, technical skill and finance.



ASEAN commitments on HIV & AIDS

Dr. Bounpheng Philavong,

**Assistant Director, Head of Health and Population Unit
Bureau of Resources Development, ASEAN Secretariat**

Dr. Philavong presented the background of ASEAN's regional response to HIV & AIDS.

The ASEAN Task Force on AIDS was established in 1992. Later, the First ASEAN Work Programme (1995-2000) on HIV and AIDS (AWPI) was developed, followed by AWPII for 2002-2005, AWPIII for 2006-2010, the Vientiane Action Programme for 2004-2010, the 7th ASEAN Summit Special Session on HIV/AIDS, December 2001 in Brunei Darussalam, and the 12th ASEAN Summit Special Session on HIV and AIDS, held in January 2007 in Cebu, Philippines.

The participants of the 7th ASEAN Summit Special Session on HIV/AIDS recognized that HIV & AIDS is not just a health problem and that it is necessary to have access to affordable drugs and testing reagents, to mainstream HIV & AIDS into national development planning, to create a positive environment to confront stigma, silence and denial, and to strengthen multi-sectoral collaboration and mobilize involvement of the community, including PLHIV.

AWPII (2002-2005) focused on PMTCT and identified the need for ASEAN Member States (AMS) to develop strategies for prevention of maternal to child transmission. AMS worked with UNICEF to commence development of these strategies. Some countries introduced testing and treatment-based strategies to

prevent the transmission of HIV to babies from mothers who know they are infected. AMS would continue to develop their own national and local strategies for prevention of maternal to child transmission. Lastly, ASEAN will focus on those aspects of this emerging issue that are not likely to be quickly implemented across AMS, that require further policy development, or that will require ongoing analysis and sharing of lessons learned about what works.

AWP III (2006-2010) became an integral component of the Vientiane Action Programme (VAP) (2004-2010). Its aim is to: prevent the spread and reduce the harm of HIV & AIDS and other infectious diseases; reduce new infection and transmission rates of HIV in ASEAN Member Countries; increase access to affordable anti-retroviral treatment and opportunistic disease treatment as well as testing reagents; integrate HIV & AIDS impact assessment into the feasibility study phase for development projects, particularly in the countries of the Greater Mekong Sub-region; conduct research on the socio-economic impact and trends of HIV & AIDS in ASEAN, with a view to mitigating the negative impacts; establish regional mechanisms to reduce proactively HIV & AIDS vulnerability arising from development-related mobility and in the workplace; and strengthen capacity of ASEAN Member Countries to reduce the vulnerability of drug users to HIV & AIDS and other blood-borne infectious diseases.

Dr. Philavong said that he is satisfied with the highly participatory process that led to the 12th ASEAN Summit Special Session on HIV & AIDS held in January 2007 in Cebu, Philippines; national consultations (April - May 2006); consultations of NGOs (Seven Sisters in May 2006); SOMHD Meeting (June 2006); ASEAN Health Ministers Meeting (June 2006); Regional Consultation (July 2006); and ASEAN Standing Committee meetings (September-December 2006).

Next, Dr. Philavong presented some specific provisions of the 12th ASEAN Summit Special Session on HIV and AIDS :

- **RECOGNIZING** that the HIV epidemic is brought about by factors such as poverty, gender inequality and inequity, illiteracy, stigma and discrimination, conflicts and disasters; it affects groups most at risk, such as sex workers, MSM, transgenders, and drug users including IDUs, and vulnerable groups such as migrants and mobile populations, women and girls, children and youth, people in correctional institutions, uniformed services, communities of populations in conflict and disaster-affected areas.
- **SUPPORTING** the 2005 World Summit call and the Political Declaration made by the United Nations General Assembly at the High Level Meeting on AIDS, held on 2 June 2006, to scale up significantly towards universal access to comprehensive prevention, treatment, care and support by 2010 for all those in need, and the reduction of vulnerability of persons living with HIV, especially orphans, vulnerable children and older persons;
- **NOTING** the Hanoi Call to Action for Children and HIV/AIDS in East Asia and the Pacific Region of 24 March 2006, which highlights nine urgent actions to scale up the response to children who are vulnerable to, and infected and affected by HIV & AIDS.

He also shared the First Operational Workplan for AWPIII (2007-2008), noting that a total of 11 projects related to PMTCT were supported by

UNAIDS, UNDP and USAID. In focusing on prevention of primary transmission of HIV to women, ASEAN supports shared development of strategies to integrate information about this into standard community HIV-awareness programmes. AWPIII aims to commence initiatives within ASEAN Member States to reduce mother-to-child transmission of HIV by preventing the primary transmission of HIV to women of a child-bearing age. Expected outcomes within two years include a wider range of strategies being made available in ASEAN Member States to prevent HIV transmission to women before or during pregnancy. Furthermore, pilot programmes are in place for the integration of gender-responsiveness strategies into general HIV-prevention policies and programmes. And, information and strategies to prevent primary transmission of HIV to women are better integrated with general HIV-prevention policies and programmes.

Strategies will include: piloting initiatives to incorporate information about PMTC transmission and prevention of spousal infection of vulnerable people into other community-awareness programmes on HIV; developing gender-specific peer education strategies to ensure that both young women and young men are informed of the vulnerabilities of women and children; developing “gender-responsiveness” strategies to reduce women’s vulnerabilities, including building psychosocial competencies, as well as life-skills and vocational training for the most vulnerable women; and increasing the number of antenatal clinics with staff trained in all aspects of PMTC transmission and encouraging men to attend antenatal clinics along with their wives or partners.

Specific activities are as follows:

1. Sharing information across countries on what attempts have already been made to address gender inequalities and the prevention of primary HIV transmission to women. This will include sharing information about: how prevention of maternal-to-child transmission initiatives can be integrated with other HIV programmes; how best to train staff of

- antenatal clinics about primary prevention of HIV to women; how to encourage men to attend antenatal clinics with their partners; how best to inform women about the risks of maternal-to-child transmission; what methods are useful for gender-specific peer-education strategies; what types of “gender-responsiveness” strategies are most useful; and how gender awareness can be incorporated into school curricula.
2. Developing pilot programmes that include training workshops for relevant agencies (HIV prevention agencies and antenatal clinic staff trainers) in three ASEAN Member States.
 3. Evaluating the impact of these pilot programmes.
 4. Sharing lessons learned through study tours to successful project sites and regional meetings.
 5. Where possible, incorporating what is learned into National HIV Strategies.
 6. Documenting lessons learned by the end of 2008 for incorporation into ongoing strategies for 2009-2010, which will include each Member State developing its own gender and HIV strategy.

Discussions

- On how FBOs are represented in a coordinating council in settings of religious diversity: The response was that there is no formula. This is an opportunity for all groups to be active participants. In some settings where a particular religious group is only a small percentage of that society, they still make a big impact in the response.
- On the role of ASEAN: It was noted that the ASEAN strategies do not mention trafficking of women and children, but ASEAN’s response was that the issue is contained in its policies on migration. It is working with UNDP on projects regarding safe migration for women and children. ASEAN will also focus on stigma and discrimination during a regional forum on empowerment of PLHIV this year in Lao PDR.
- On the role of AusAID: In response to a question about its support for civil society groups, Australia pointed to its support of PLHIV networks, which did not exist five years ago, in Papua New Guinea. Because of the Universal Access targets for 2010 and the MDG targets for 2015, Australia has emphasized working with governments to ensure that they are doing all they can to reach these targets. Australia supports civil society groups, however, as part of the systematic response.

Presentation and performance by children and young people living with HIV in Thailand

Chiranuch Premchaipron

Manager of Prachathai and the Children of the We Understand Group

The We Understand Group was founded in 2004 for the purpose of teaching and encouraging children living with HIV to use art as a tool to communicate and express their feelings. Art can be a healing tool. The outcome is not just about works of art but is an ongoing process of the children growing up.

The children of the We Understand Group staged an inspiring performance piece similar to modern dance in which they expressed their feelings of isolation, rejection and ultimately healing. Dressed in masks and colourful costumes of their own design, they danced while works of art were projected on a screen behind them. The masks, however, were not solely for the purpose of dramatic effect. Stigma and discrimination are still serious problems in Thailand, and so the children's identities must be protected. Captions

projected on the screen evoked their feelings. Some read:

"Everyone else has a family, but I am alone watching them. Lonely feelings."

"I just want everyone else to look at me as a normal child, not a special child. I just want to be a child."

"I am not living with a deadly disease like what people think, but rather living in a deadly world with people who don't understand and are unwelcoming."

"I want to have friends, study, do everything, have a girlfriend."

"HIV is not completely bad. At least it brought us together."

Discussions

The children of the We Understand Group answered questions from participants. According to the children, "The most important thing is for society to understand and accept PLHIV because we still have a life and have to go to school. When there are activities the other students don't accept us; we have no chance to join in. With feelings of encouragement they said they will have the strength to live."

Encouragement and strength come from being understood by other people. The children would like to go to pray and communicate with others in other parts of the world, and they want organizations such as UNICEF to work with them so that children in other countries can have groups such as this, groups that let more children join and help them to enjoy life and have fun. The children of the We Understand Group don't show their faces because there is still lack of understanding from others. When they think about past experiences, it still hurts. But people are more accepting now than they were four or five years ago.

One thing that was especially difficult was learning about their status. For most of these children, no one told them. They learned by reading the medicine bottles in their house. Adults should be honest with children but also assess their understanding to know what they can comprehend about their situation. It must be an ongoing process.

Those who work with children with HIV should be concerned about their feelings and emotions. If they are sad, bring happiness to their lives. Do not say anything that will hurt them more. Be careful when you speak with children. Have a good attitude towards them. Performance art is 'a dream come true,' as it allows the children to express themselves and communicate their message to many people. Their dreams are to grow up and live normal lives, to increase understanding among people about children with HIV. Now, they said, they have passed on these dreams on to all attending.

Consolidated group outputs: “Next steps”

Participants were divided into eight working groups. The purpose of the session was to provide delegates with an opportunity to identify obstacles and priority areas for action to scale up responses for children who are vulnerable to, infected and affected by HIV & AIDS. Each small group was asked to brainstorm the following questions:

- What are the priorities for future action?
- What are the challenges and obstacles to achieve the desired outcomes based on such priorities?
- What specific measures to overcome challenges could be proposed (at national and regional levels) based on lessons learned to ensure that we address these priorities?

Priorities for future action

1. Scale up policy implementation of all Ps and best practice models (i.e. family-centred care, decentralized continuum of care models); scale up PMTCT and increase access to paediatric ARV, including to the private sector
2. Reduce stigma and discrimination
3. Access high-risk groups: link young MARPS to all four P's; within existing National Plans on HIV, prioritize action for MARPs/MARAs, women of child-bearing age and their male partners, including fund mobilization; social protection services to scale up emphasis on the most vulnerable groups
4. Alternative care services for OVC (kinship care, day care, simulation families, temporary care, group home, safe houses); holistic approach to address the physical, mental and psychological needs of children living with/affected by HIV & AIDS.
5. Strengthen inter-sectoral coordination in order to have comprehensive responses on the four Ps and their harmonization; engage and improve collaboration with civil society and FBOs, especially in community outreach
6. Cost national plans
7. Strengthen M&E frameworks, tools and data collection and analysis
8. Mobilize resources for children-specific services; advocate for increased resources based on evidence; engage the private sector in fundraising (e.g. in China, a mobile campaign for foster care budgeted at US\$ 7 million) and in service provision and referrals, e.g. PMTCT
9. Have emergency preparedness and response plans that incorporate action to avoid disruption of services related to all Ps (for disaster-prone areas)
10. Increase PLHIV participation, allowing for them to provide input/build on alliance
11. Standardize the definition of children

Challenges and obstacles

1. Scaling up policy implementation of all Ps and best practice models (i.e. family-centred care, decentralized continuum of care models); scaling up PMTCT
 - Referral and collaboration among different stakeholders, as well as unclear division of labour at the provincial and grassroots levels
 - Weak capacity of providers
 - Difficulty channelling from national to lower levels
 - Difficult to extend services to scattered populations in remote areas
 - Limited access to C&T in concentrated epidemic
 - Lack of integration of FP/RH into HIV services
 - VCT – unclear number of people who know their HIV status

2. Reducing stigma and discrimination
 - Challenge to mitigate stigma and discrimination
 - Entrenched stigma and discrimination in health work force
 - Double stigma for HIV-positive MARPS (people who are already marginalized)
 - Change happens only over a long period of time
 - Decreased utilization of services due to stigma and discrimination, loss to follow up and restricted access to services
3. Accessing high-risk groups
 - MARPs are hard to reach; difficult to find young MARPS, and thus hard to target (criminalization, stigma and discrimination)
 - Understanding the needs of young MARPS
 - General/institutional care
 - Cycle of inter-generational MARPS
 - Government-focused services rather than community-based
4. Alternative care services for OVC
 - Stigma in caring for OVC in communities
 - Lack of incentives for alternative care services
 - Lack of guidance and frameworks to support alternative care services
 - Misperception that “alternative care” is more difficult to manage and is more costly
 - Lack of awareness of best practices
 - Community-based care – lack of practices (contextual) and labour intensive process
5. Strengthening inter-sectoral coordination
 - Not all stakeholders are on board, and competition for funding and resources is fierce
 - Coordination among different sectors still weak
 - Coordination issues – different mandates, priorities, interests
 - Inadequate capacity of midwives, health systems delivery overburdened
6. Costing national plans
 - Limited technical and resource capacity
 - Hard to share information on existing budgets from government ministries, NGOs and others
7. Strengthening M&E frameworks, tools, and data collection and analysis
 - Limited capacity for data collection and analysis, including for evaluation of programmes, especially at lower levels and for some NGOs/CBOs
 - Different partners use their own M&E approaches and indicators
 - Difficult to measure success, since it happens over a long time-period
8. Mobilizing resources for children-specific services and engaging the private sector
 - Limited technical and financial resources; lack of funds for transport
 - Untapped resources and lots of unknowns
9. Having emergency preparedness and response plans
 - HIV not included in emergency response plans, so HIV services in emergencies are not prioritized
10. Increasing PLHIV participation
 - Involvement of PLHIV is difficult, lack of political will, heavy reliance on mass media interventions (untested and design is not evidence-based), lack of law enforcement, lack of basic HIV knowledge

Measures to overcome challenges

1. Scaling up policy implementation of all Ps and best practice models; scaling up PMTCT
 - Define country-level strategy for linking four Ps
 - Develop provincial and local plans of action jointly by sectors
 - Apply 'Three Ones' principle not only at national level but also at lower levels
 - Examine guidance/cost-effectiveness and feasibility of different models, innovations/documentation of 'best practice' and innovative models; for PMTCT in concentrated epidemics, more focus on unintended pregnancy
 - Scale up quality of prevention services – PMTCT, community-based care for most-at-risk youth, and comprehensive PMTCT
 - Increase VCT through PITC
 - Improve law and guidance on counselling and testing minors/youth
 - Include PMTCT and impact mitigation for children in GFATM and other proposals
2. Reducing stigma and discrimination
 - Better guidance (reinforcement) in implementing stigma and discrimination reduction on the ground
 - Bottom-up community-based approaches
 - Attention to implementation of AIDS law with matching resources
 - Capacity building/in-service/monitoring and support to health workers involved in HIV
 - Life-skills approach: scale up prevention of stigma reduction
 - Addressing stigma and discrimination at a larger and community level: policy, education of general public, community leaders
 - HIV & AIDS to be a part of pre-service training of health workers, teachers and social workers
3. Accessing high-risk groups
 - Target high-risk groups
 - Take services to MARPs (community-based, accessible, appropriate, incentives)
 - Involve MARPs in planning health and other services and in implementation (including outreach and mobile services)
 - Decriminalize high-risk behaviours (sex workers, MSM and drug use)
 - Scale up evidence-based harm-reduction products to saturate the market
 - "One-stop shop" linked services for MARPs and their families and children
 - Develop interventions for out-of-school youth, including policies to reach out to this group, job placements/programmes of employment
 - Develop programmatic interventions: life skills – funds, human resource capacity, application, best mechanisms to scale up; identify good models, mechanisms to scale up
 - Increase dialogue/formal mechanisms for MARPs groups and policy-makers
4. Alternative care services for OVC
 - Review legislation on institutional care
 - De-incentivize costly institutional care
 - Increase resources/capacity for case managers (family prevention, family placement)
 - Develop cost-effective models for alternative care suitable for country-specific settings
 - Professionalize social work within the child welfare system
5. Strengthening inter-sectoral coordination
 - National and provincial level fora for buy-in on all aspects of children and AIDS
 - Inclusive consultative processes prior to submission of funding proposals (i.e. GFATM)

- Strengthen/develop mechanisms for coordination between local government agencies, ministries and international agencies; institutional strengthening at national and provincial levels (monitoring and supervision); for comprehensive PMTCT interventions – coordination between communities and services, establishing linkages and referral systems
 - Better case management and social network strengthening
 - Linkages with local organizations and NGOs
6. Costing national plans
 - Provide technical assistance
 - Put in place mechanisms for better sharing of information
 7. Strengthening M&E frameworks, tools and data collection and analysis
 - Agree on key indicators and instruments, in line with international reporting requirements that all implementers (government, private sector, NGOs, donors, etc.) have to routinely report on
 - Strengthen capacity and means of central and provincial M&E units
 - Increase evidence-based programmes
 - Improve M & E, capacity building, practice
 8. Mobilizing resources for children-specific services; engaging the private sector
 - Partnership with the private sector, address national HIV budget
 - Need to explore how to engage the private sector
 - Civil society funds are easiest to mobilize when channelled to grassroots level
 - Need to increase capacity in funding management, as well as structural systems in place to channel funding
 9. Having emergency preparedness and response plans
 - Incorporate HIV response under the umbrella of health response
 10. Increasing participation of PLHIV
 - Strengthen PLHIV groups
 - Involve PLHIV in clinical/community care

Closing

At the closing of the forum, UNICEF Deputy Regional Director Richard Bridle read the Draft Statement of Commitment (refer to Annex A). This was followed by the Closing Statement.



Closing Statement

Anupama Rao Singh, Regional Director, UNICEF East Asia and the Pacific Regional Office

“We need to ensure that we continue to build on our achievements, while recognizing that we still have an unfinished agenda.”

The following is the full text of Ms. Singh’s closing statement:

I am very pleased to close the forum with the understanding that you have come to a meaningful consensus on a number of key issues. From the statement, I can see that a lot of ground has been covered during the past three days. It is indeed heartening to see that there has been progress over the past two years, and many meaningful actions have been taken and presented by country delegates over the last three days. I’m pleased to note that you’re working toward strengthening systems and partnership and inter-departmental coordination. There is also increased recognition of the child- and family-centred approach and convergence of the 4 Ps around local epidemics.

To all of you who have been striving to develop such policies, programmes and services, I congratulate you on your efforts, commitment and excellent progress. Within our region there remain great concerns that HIV is increasing at particularly high rates in some countries. And the growth trajectory will mean that the number of children affected and orphaned by AIDS will continue to rise.

Thus, while HIV prevalence may be low in East Asia-Pacific compared to other regions, there is no room for complacency. Further, large

population sizes conceal grave issues that children and adults confront locally as HIV and AIDS rob them of their sense of hope and well-being.

I know over the last three days, many of you have debated what further action is required. I would like to add my thoughts to them:

- We need to continue to ensure there is political commitment at all levels that supports the response to HIV and most importantly that takes in account the impact HIV has on the lives of children.
- We need to continue to ensure that we actively involve young people as partners in our response.
- Strong partnerships already exist. Yet when we are dealing with the impact of HIV on children we need to ensure that, in particular, strong partnerships are developed with the education sector and child protection sector and between public health, education, social welfare and national planning systems.
- We need to continue to ensure that we improve our country-level analysis of the situation of children and respond accordingly.

It is my sincere hope that you leave this forum feeling a renewed sense of commitment and energy to address the issues facing children in the region. Very importantly, I hope that you come away with the knowledge you need to advocate for the needs of children in your own work.

As we reminded ourselves at the start of this forum, the young people who attended the Hanoi Consultation had asked for action, so I will end it with a call to action. We need to act. We need to ensure the commitments as outlined in the Forum Statement are not empty words but have meaning. We need to ensure that we continue to build on our achievements, while recognizing that we still have an unfinished agenda.

Annex A:

Statement of Commitment of the East Asia and Pacific Regional Partnership Forum on Children and HIV and AIDS

2 April 2008, Bangkok, Thailand

Introduction

We, 133 delegates from 17 countries, participating in this Forum reaffirm the commitment made in Hanoi, Viet Nam on 24 March 2006 to minimize the impact of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) on children and young people as well as to prevent the continuing spread of HIV and AIDS by protecting children and young people from a host of vulnerability and risk factors that drive the spread of HIV in the East Asia and Pacific region.

Progress

We recognize that there has been much progress since the **Hanoi Call to Action**, namely:

- Country-level analyses of the situation of children and HIV and AIDS have become more available based on improved qualitative/quantitative methods and guidelines to guide efforts to plan, strengthen and scale up responses to children and young people. A number of countries have conducted assessments of children living with and affected by HIV and AIDS.
- Many countries have refined legislation and developed policies and guidelines to reduce mother-to-child transmission and increase paediatric HIV treatment, and protect and care for children and families living with and affected by HIV and AIDS. A number of countries have set up national integrated prevention of mother-to-child HIV transmission (PMTCT) programmes, some of which also involve male partners, and have developed national PMTCT training curricula and national scale-up plans.
- All countries have initiated a range of prevention, treatment and care actions for and with children and young people, and some are already scaling these up. Some have developed national strategies and/or set up national task forces to strengthen social protection of orphans and vulnerable children and young people, including those living with and affected by HIV and AIDS.
- Many countries are increasingly pursuing a family- and child-centred approach to HIV and AIDS, and improving monitoring and reporting systems for HIV-infected mothers and children during and after delivery.
- Regional and international cooperation on policy, networking, information sharing and research to scale up responses has been enhanced through active partnership. A notable example was the affirmation of the Hanoi Call to Action by the Association of Southeast Asian Nations (ASEAN) at its 12th ASEAN Summit Special Session on HIV and AIDS held in Cebu City, the Philippines in January 2007.

- Faith-based organizations throughout the region have redoubled their effective and coherent action. At their Interfaith Consultation Meeting, held in Bangkok, Thailand from 15 to 17 January 2008, they have committed to work to build supportive environments, mobilize and support community-based responses, strengthen the capacities of families, and ensure access to essential services.

Challenges

We recognize, however, that there are still challenges:

The growth trajectory of HIV and AIDS in East Asia and Pacific merits attention, especially the consequences on children and young people. With the infection profile becoming younger and the epidemic increasingly feminized, the number of children and young people living with, born HIV positive, and orphaned or made vulnerable by HIV and AIDS is certain to rise. Existing figures do not capture the entire picture given limitations of current estimation and projection techniques, as well as under-reporting caused by stigma and discrimination.

The response to children and young people who are vulnerable to, living with and affected by HIV and AIDS is still inadequate in the region. Many children and young people at risk are unaware of how to protect themselves from HIV and AIDS and do not have access to appropriate information, essential services and required materials. In addition, many children and young people living with HIV do not know their HIV status and do not have access to sufficient care, support and treatment services.

From current observations, the prospects for many children and young people living with and affected by HIV and AIDS in this region are still a cause of grave concern. They experience losses in their early age: loss of parents, loss of security and warmth, and the overall well-being of their family. Many are left to fend for themselves, hurt from a young age by stigma and discrimination associated with HIV and AIDS and denied basic education, health, nutrition and other rights. Above all, there is a strong possibility that many would be at risk growing up repeating the perilous journey of their parents and adopting risk behaviours out of pressing needs for survival. Many of them are deprived of care-givers' guidance and hope for a better future, because they are denied equal opportunities for healthy growth and development.

Voluntary and confidential counselling and testing (VCCT) services are not yet widely available in most countries, and such services are not always tailored to the needs of children and young people. Many women and their partners remain unaware of their HIV status and have inadequate knowledge of VCCT, while antiretroviral treatment (ART) is not yet widely accessible by mothers, children and young people in need. Inadequate access to ART discourages people from seeking HIV testing and counselling. Stigma and discrimination associated with AIDS further discourage care-seeking behaviour.

Actions agreed upon

We are committed to work to reduce the impact of HIV and AIDS on children and young people and to halt the continued spread of HIV, recognizing that the "Four Ps" of the Global Campaign *Unite for Children, Unite Against AIDS* form the basis of a comprehensive response for children and young people: **P**MCTCT, **P**aediatric treatment, **P**revention of infection among children and young people, and **P**rotection and support of children and young people living with and affected by HIV and AIDS. We are determined to link to this approach and to scale up good examples of the family-centred continuum of care (CoC) at national and sub-national levels, bringing about the most effective outcomes for children and young people and ensuring linkages among the four Ps for a holistic, comprehensive response.

We recognize the necessity to adapt the regional framework based on the unique regional and country situations, including differences within countries, and to take further actions based on surveillance as well as monitoring and evaluation systems to determine the best strategies and outcomes.

We believe that our continued actions and renewed efforts at the sub-national, national and regional levels can make a real difference in the lives and futures of children, young people and their families in East Asia and Pacific.

We have identified the following actions, building upon what has been achieved so far:

- Improve coverage of prevention programmes by ensuring sustainable mechanisms for capacity building to: provide children and young people with greater access to appropriate age-specific and gender-sensitive information on HIV and AIDS, relevant skills and access to youth-friendly reproductive health services; create supportive social environments; and direct prevention education specifically towards vulnerable children and young people who may engage in risk behaviours leading to HIV infection.
- Continue to scale-up PMTCT and paediatric treatment including ensuring: greater male partner and community involvement; linkage to reproductive, maternal, newborn and child health and nutrition services; appropriate targeting of services based on epidemiological characteristics of each country; access to quality and affordable ART; counselling and education on infant feeding; and continuing access to and utilization of different counselling and testing services.
- Protect and support children and young people living with and affected by HIV and AIDS by implementing effective and appropriate strategies as part of national welfare and social protection systems to: meet their economic and social needs; develop appropriate family-based and community-based models of care; develop minimum standards of care; and support extended families or alternative care arrangements; and more generally improve their access to overall health, social welfare and education services.
- Strengthen data systems, research, monitoring and evaluation, as well as the sharing of information on best practice experiences to improve the delivery and effectiveness of programmes, including ensuring the needs of children and young people living with and affected by HIV and AIDS are well-assessed based on empirical research in each country and across the region and that ongoing monitoring of the socio-economic and psychological impact on these children is in place to inform policy and programme responses.
- Allocate technical, financial and human resources needed for adequate and sustainable policy, programmes and services, ensuring that these resource allocations are appropriate and cost-effective in reflecting the epidemiological patterns of the country, at both national and sub-national levels.
- Address barriers to reducing stigma and discrimination to foster greater support and understanding of children and their families living with and affected by HIV and AIDS, and assure their access to essential services.
- Strengthen strategic partnerships at the national and regional levels by ensuring involvement and coordination of activities among partners, particularly with governments, international organizations, donor agencies, civil society and faith-based organizations, and the private sector.

- Encourage and provide for the meaningful and ethical participation of children and young people living with and affected by HIV and AIDS in the various phases of responses affecting their welfare at all levels; continuously develop and build their capacities to articulate their views and concerns and propose actions appropriately, these inputs being considered part of the design, implementation and evaluation of policies, programmes and services on their behalf; facilitate and support the organization of groups or networks of children and young people living with and affected by HIV and AIDS and their alliances with other children and young people in similar situations within countries, regions and in order to propose and undertake actions alongside adults.
- Promote effective mechanisms to address violations of rights of children, young people and their families living with and affected by HIV and AIDS.

Conclusion

Through this Partnership Forum, we have reaffirmed that an effective response to children and young people who are vulnerable to, living with and affected by HIV and AIDS in East Asia and Pacific requires strong political leadership, sustainable financing, multi-sectoral partnership, and meaningful participation of civil society organizations, children, young people and people living with HIV, and communities affected by HIV and AIDS at the regional, national and sub-national levels.

The country delegations of this Forum thank the organizers and supporters¹ for their contributions to this Regional Partnership Forum. We are firmly convinced that our strong regional partnership will bring effective outcomes for children, young people and their families in East Asia and the Pacific.

¹ The organizers of the forum were the United Nations Children's Fund (UNICEF), Joint United Nations Programme on AIDS (UNAIDS) and United States President's Emergency Plan for AIDS Relief (PEPFAR). Supporters included the United States Agency for International Development (USAID), United Kingdom Department for International Development (DfID), Swedish International Development Agency (Sida), Australian Agency for International Development (AusAID), Family Health International, Save the Children Alliance, Clinton Foundation HIV and AIDS Initiative, World Health Organization (WHO), United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Population Fund (UNFPA), United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), Association of South-East Asian Nations (ASEAN) and the World Bank.

Annex B: Agenda

Day One: Monday, 31 March 2008	
8:30-9:40	<p>Opening plenary Chair: Mr. Tomoo Hozumi, Representative of UNICEF Thailand</p> <p>Welcome</p> <ul style="list-style-type: none"> • Ms. Anupama Rao Singh, Regional Director, UNICEF East Asia and Pacific Regional Office <p>Opening speeches</p> <ul style="list-style-type: none"> • Mr. J.V.R. Prasada Rao, Director, UNAIDS Regional Support Team for Asia and the Pacific • Mr. Jimmy Kolker, Chief, HIV and AIDS, UNICEF New York • Ms. Cathy Bowes, Director, Office of Public Health, U.S. Agency for International Development, Regional Development Mission/Asia • Mr. David Claussenius, Asia Regional Director, Save The Children USA
10:10-10:30	<p>Keynote address H.E. Mr. Anand Panyarachun, former Prime Minister and UNICEF Goodwill Ambassador for Thailand</p>
10:30-12:00	<p>Session 1: National responses following Hanoi Chair: Mr. Jacinto Rigiberto Gomes de Deus, Secretary of State for Social Solidarity, Ministry of Social Solidarity, Timor Leste</p> <ul style="list-style-type: none"> • Dr. Nguyen Trong An, Vice Director Children Department, Ministry of Labour, War Invalids and Social Affairs, Viet Nam • Dr. Siripon Kanshana, Deputy Permanent Secretary, Ministry of Health, Thailand • H.E. Dr. Teng Kunthy, National AIDS Authority, Cambodia • Dr. Han Mengjie, Deputy Director, National Center for AIDS/STD Control and Prevention, China • Dr. Chansy Phimphachanh, Director of Center for HIV/AIDS/STI, Ministry of Health, Lao PDR • Dr. Jose Gerard Belimac, Program Manager, the National AIDS/STI Prevention and Control Program, Department of Health, Philippines
1:30-3:00	<p>Session 2: Protection and care: Global and regional approaches Chair: Dr. Michael Samson, Director of Research, Economic Policy Research Institute</p> <ul style="list-style-type: none"> • Reframing strategies for children and HIV in Asia and the Pacific region – Mr. Jerker Edström, Research Fellow, Institute of Development Studies/ Consultant UNICEF East Asia and Pacific Regional Office • Children affected by AIDS and orphans and vulnerable children in low prevalence countries – Dr. Barton Burkhalter, Director of Operations Research and Associate Director, Quality Assurance Project, University Research Co., LLC • Operationalizing the continuum of prevention, care, and protection for children, adolescents and families in Asia and the Pacific – Dr. Celine Daly, Director, Technical Unit Asia Pacific Regional Office, Family Health International • Companion paper and applications to East Asia and the Pacific Region – Mr. Aaron Greenberg, Child Protection Specialist, UNICEF New York <p>Questions and answers</p>
3:30-5:00	<p>Session 3: Country examples responding to children affected by HIV and AIDS Chair: Hon. Francisco T. Duque III, Secretary, Department of Health, Philippines</p> <ul style="list-style-type: none"> • Consultation on the cash transfer program in Papua New Guinea – Dr. Michael Samson, Director of Research, Economic Policy Research Institute, South Africa/ Consultant of UNICEF East Asia and Pacific Regional Office • Provincial policies of children affected by AIDS in Henan province in China – Mr. Yang Guangwei, Deputy Division Director, Department of Social Welfare and Social Affairs, Ministry of Civil Affairs, China • National plan of actions for orphans and vulnerable children – H.E. Keo Borent, Ministry of Social Affairs, Veterans and Youth Rehabilitation, Cambodia • Progress in care and support in Myanmar – Mr. Aung Tun Khaing, Deputy Director General, Department of Social Welfare, Ministry of Social Welfare, Relief and Resettlement, Myanmar (TBC) • Family-centered care – Dr. Rachel Burdon, Senior Technical Advisor on Care and Treatment, Family Health International Vietnam <p>Questions and answers</p>
5:00-6:00	<p>Forum statement committee meeting (Heads of delegation only) Chair: Mr. Richard Bridle, Deputy Regional Director, UNICEF East Asia and Pacific Regional Office</p>

Day Two: Tuesday, 1 April 2008

8:30-10:00	<p>Session 4: Evidence-based approach: Progress made since Hanoi Chair: Mr. Jerker Edström, Research Fellow, Institute of Development Studies</p> <ul style="list-style-type: none">• Estimation, monitoring and evaluation of children affected by HIV and AIDS, East Asia Pacific region - Dr. Priscilla Akwara, UNICEF New York• National assessment of families and children affected by HIV and AIDS in Indonesia – Dr. Sabarinah Prasetyo, Director, The Center for Health Research, Indonesia• Household assessments of children affected by AIDS in China – Dr. Yuan Jianhua, Senior Fellow, Beijing Institute of Information and Control, China• The HIVQUAL model for performance measurement and quality improvement in pediatric HIV care – Dr. Kim Fox, Centers for Disease Control Global AIDS Program in Thailand• Asian Pacific epidemics and appropriate approaches - Dr. David Wilson, Acting Director, Global HIV/AIDS Program, The World Bank, Washington DC (via video and phone) <p>Questions and answers</p>
10:30-12:00	<p>Session 5: Preventing infection among young people Chair: Dr. Han Mengjie, Deputy Director, National Center for AIDS/STD Control and Prevention, China</p> <ul style="list-style-type: none">• Provider initiated testing and counseling for low prevalence settings – Ms. Kathleen Casey, Senior Technical Officer, Family Health International, Asia Pacific Regional Office• Knowing your status, plan your future: youth prevention in Papua New Guinea – Dr. David Passirem, Manager Care and Counseling, National AIDS Council Secretariat, Papua New Guinea• Preventing HIV among young men in Vietnam: affecting gender norms and risk practice– Ms. Lisa Sherburne, Save the Children USA, Vietnam• Targeting high risk youth, Mr. Natthapong Suksiri, Project Coordinator, Thai Youth Network on HIV/AIDS, National, Thailand <p>Questions and answers</p>
1:30-3:00	<p>Session 6: Prevent mother-to-child transmission and paediatric treatment Chair: Dr. Shaari Ngadiman, Senior Principal Assistant Director, AIDS/STD Unit, Ministry of Health, Malaysia</p> <ul style="list-style-type: none">• Improving prevention through strengthening health system: The “Joint WHO-UNICEF-UNPFA-UNAIDS Asia-Pacific Operational Framework for Linking HIV/STI Services with Reproductive, Adolescent, Maternal, Newborn and Child Health Services” – Ms. Wing Sie Cheng, Regional HIV adviser, UNICEF East Asia and Pacific Regional Office• Linked response in Cambodia – Dr. Mean Chhi Vun, Director, National Center for HIV/AIDS, Dermatology and STDs, Ministry of Health, Cambodia• Scaling-up pediatric AIDS treatment and prevention of mother-to-child transmission in Asia-Pacific – Dr. Erik Fleischman, Senior Clinical Advisor, Clinton Foundation HIV/AIDS Initiative, Thailand (TBC)• Pediatric HIV management towards greater survival of children living with HIV in Thailand – Dr. Rawiwan Hansudewechakul, Chief Pediatrics Department, Chiangrai Prachanukroa Hospital, Thailand <p>Questions and answers</p>
3:20-4:30	<p>Group work: How to link the 4 Ps around local epidemics? Divide into eight small groups</p>
4:30-5:30	<p>Report back Chair: Dr. Celine Daly, Director, Technical Unit Asia Pacific Regional Office, Family Health International</p>
5:30-7:00	<p>Forum statement committee meeting (Heads of delegation only) Chair: Mr. Richard Bridle, Deputy Regional Director, UNICEF East Asia and Pacific Regional Office</p>

Day Three: Wednesday, 2 April 2008

8:30-10:00	Session 7: Partnership Chair: Dr. Mean Chhi Vun, Director, National Center for HIV/AIDS, Dermatology and STDs, Ministry of Health, Cambodia <ul style="list-style-type: none">• Australia's contribution to HIV responses in Asia-Pacific, H.E. Mr. Phillippe Allen, Minister Counselor, Mekong and Regional (MER), Australian Agency for International Development• US Government's Contribution to Partnership for Children and AIDS, Ms. Cathy Bowes, Director, Office of Public Health, U.S. Agency for International Development, Regional Development Mission/Asia• Greater involvement of people and women living with HIV – Ms. Frika Chia Iskander, Coordinator, Women of Asia Pacific Network of People Living with HIV/AIDS• Commitment of faith-based groups to HIV prevention and protection, care and support for children in East Asia-Pacific – Dr. Rabia Mathai, Senior Vice President Global Program Policy and Planning, Catholic Medical Mission Board• ASEAN's commitment to HIV response – Dr. Bounpheng Philavong, Assistant Director, Head of Health and Population Unit, Association of Southeast Asian Nation Questions and answers
10:30-12:00	Youth presentation and performance by 15 youth living with HIV in Thailand Facilitator: Ms. Chiranuch Premchaiporn, "we understand" group
1:00-2:00	Group Work: Next steps Divide into eight small groups
2:00-3:00	Report back Chair: Mr. Aaron Greenberg, Child Protection Specialist, UNICEF New York
3:20-3:45	Group photo
3:45-4:30	Closing Presentation of Forum Statement <ul style="list-style-type: none">• Mr. Richard Bridle, Deputy Regional Director, UNICEF East Asia and Pacific Regional Office

Annex C: List of Forum Participants

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